Workbook

Describe common substance and non-substance addictions in New Zealand, their effects, and types of addictive behaviour
US 27076
Level 4
Credits 8

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Before you start

Welcome to this workbook for:

Describe common substances and non-substance addictions in New Zealand, their effects, and types of addictive behaviour

Unit Standard 27076.

For this unit standard you will have:

- This workbook.
- A trainee assessment.

In this workbook you will learn more about:

- Common substances and non-substance addictions in New Zealand.
- The effects the addictions have on the user.
- The effects the addictions have on the natural supports.
- Types of addictive behaviour and their motivating factors and characteristics.
- Actions that can be taken to address addictive behaviours.

How to use this workbook

- This is your workbook to keep – make it your own by writing in it.
- Use highlighters to identify important ideas.
- Do the learning activities included throughout this workbook. Write your answers in the spaces provided.
- You might find it helpful to discuss your answers with colleagues or your supervisor.
- Finish this workbook before you start on the assessment.

Take note!

When you see a sticky note like this, it gives a tip or hint.
Workbook activities

Stop – check what you know about this topic
You will see this stop symbol in places where you are asked to stop and think about what you know and:

- Record your current knowledge or impressions.
- Check your knowledge.

This stop provides a reference point to return to later. Stop activities have blue shading like this.

Learning activities
You will come across learning activities as you work through this workbook.

These activities help you understand and apply the information that you are learning about.

Learning activities have yellow shading like this.

Rewind
When you see this rewind symbol, go back to:

- Think about what you know.
- Check your knowledge.

This rewind gives you an opportunity to add to, change or confirm some of your initial thoughts and ideas. Rewind activities have green shading like this.
Common substance addictions

When considering common substance addictions in New Zealand, it is important to take into consideration some important factors about substances.

1 What is the substance?
   It is important to have a good understanding of each substance and the components that make up the substance. Often, substances are called various names so it is significant to be familiar with a variety of common names for each substance. Also, how substances are administered and absorbed into the body will vary depending on the drug, so it will be important to be familiar with these distinctions.

2 Effects of the substance.
   It is valuable to know the effects of each substance. Use of drugs in low to moderate levels will have different effects on a person than using a substance at a higher dose. As the diagram below shows, increased use of a substance causes increased problem-severity.

   ![The problem-severity continuum](image)

3 Legal issues.
   Even though some legal information may be obvious and common knowledge, such as, what substances are legal and not legal, there are other legal ramifications to take into consideration. For instance, the legal classification of a drug (class A, B or C) will determine the consequences associated with the drug.

4 Prevalence and at risk populations.
When considering substances, it is important to know what drugs are affecting New Zealand most. There also are correlations between drugs used and such variables as ethnicity, gender, age and socioeconomic status.

All these factors will be taken into consideration when working through an understanding of common substance addictions in New Zealand.

**Diagnostic manual**

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the standard classification of mental disorders used by mental health professionals. The DSM is the most influential text in the diagnosing of addictions and disorders.

The DSM has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. It can be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counsellors.

The DSM has had five editions with the DSM-5 being the most up to date. The DSM-5 has relabelled substance-related disorders to addiction and related disorders.

Within the DSM-5, the criteria of substance abuse and substance dependence as separate criteria have been changed into a new continuum of substance related and addictive disorders. How the frequently used criteria apply to each substance will be covered in this workbook.

The DSM-5 establishes nine types of substance-related disorders:

1. Alcohol
2. Caffeine*
3. Cannabis (e.g., marijuana)
4. Hallucinogens
5. Inhalants
6. Opioid (e.g., heroin)
7. Sedatives, Hypnotics, or Anxiolytics (e.g., benzodiazepines)
8. Stimulants (cocaine, methamphetamine)
9. Tobacco

*Substance use disorder does not apply to caffeine.
Regardless of the particular substance, the diagnosis of a substance use disorder is based upon a pathological set of behaviours related to the use of that substance. These behaviours fall into four main categories:

1. Impaired control.
2. Social impairment.
3. Risky use.
4. Pharmacological indicators (tolerance and withdrawal).

Substance use disorder in the DSM-5 is a maladaptive pattern leading to clinically significant impairment or distress for at least 12 months.

There are 11 criteria and severity of disorder is measured along a continuum by:

- Mild where a person meets 2-3 criteria.
- Moderate meeting 4-5 criteria.
- Severe meeting 6 or more criteria.

Criteria are grouped into four groups.

- A reduced ability for a person to control actions of obtaining, using, or wanting to use (criteria 1-4)
- Social impairment is the effect on relationships and involvement in whanau, work, education and recreation (criteria 5-7)
- The continued risky use in physical situations and use despite knowledge of health issues made worse by the substance use
- Pharmacological criteria includes tolerance (needing to use more to get the same effect and withdrawal symptoms when use is stopped (criteria 10-11)

Where applicable, there are criteria for intoxication and withdrawal.

- “Intoxication criteria” are the effects after ingestion of, or exposure to, the substance.
- “Withdrawal criteria” are the signs and symptoms that occur after cessation of, or reduction in, heavy or prolonged use of a substance.
Before you go any further in this workbook, think about these scenarios.

Use your instincts to determine the following scenarios. Later in your learning come back to these scenarios to see if your thoughts have changed. Fill in a rating number and any comments for each behaviour based on the below continuum.

### The continuum of substance use problems

<table>
<thead>
<tr>
<th>No use</th>
<th>Social use</th>
<th>Moderate problems</th>
<th>Serious problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: Relative severity is a guide only. Actual severity depends on assessment. The first answer is done for you, in red. Suggested answers are on page 56.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt really embarrassed; couldn’t remember what she did last night or how she got home.</td>
<td>5</td>
<td>More serious if it has happened several times.</td>
</tr>
<tr>
<td>He wakes up after a heavy night, has shaking hands, and reaches for another drink.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five months pregnant, she pours herself a glass of wine, lights another cigarette.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On the job, he finds himself continuously looking at the clock for closing time as he is dying for a drink.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>They called the police again after hearing the neighbour come home drunk and start beating up his wife.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He’s been using escalating amounts of methamphetamine over the last six months to keep his competitive edge at work.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He’s on his second warning from work for too many days off, always on Mondays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He freaked out after an acid flashback.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She’s over the legal limit at a motorway police check after a night out with friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets a pat on the back from his mates outside the grocery store for getting away with a 12 pack of beer without ID.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He promised his girlfriend that this time, he would only have a few at the local tonight.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She pours vodka taken from her parents’ home bar into her hip flask before she goes out to a party.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He is begrudgingly at the bach for the family holiday. His parents notice he’s irritable and not sleeping well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After the kids are put to bed, he goes outside to smoke the joint he just rolled.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looking gaunt and covering up the track-marks on her arms, heavily made-up, she stands on the street waiting for a trick.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instead of stealing one tube of glue, he thought he’d try for three this time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The parties are always at his house because he never runs out of booze.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As soon as he walks in the door, his mum confronts him about the two joints in his room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being a recreational user of drugs like ecstasy, LSD and cannabis since his teens, he tries P for the first time at a party.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Diagnosing substance use disorder

The term “addiction” has undergone transformations. For many years, addiction was understood as dependence. The term addiction was abandoned when substances were seen from issues of tolerance and withdrawal more than through physical and psychological factors.

Within past DSM frameworks, abuse and dependence were separated and included as a group of symptoms that includes dyscontrol, salience, compulsion to use and physiological features which are tolerance and withdrawal.

Dyscontrol
- Substance is often used more than intended.
- Unsuccessful attempts to cut down or control use.

Salience
- Much time is spent in substance use.
- Important activities are given up or reduced.

Compulsion to use
- Continued substance use despite knowledge of associated medical or psychological problems.

Physiological features
- Acquired tolerance.
- Withdrawal symptoms and/or relief use.

The DSM-5 adds an additional factor.

**Craving, a physiological factor**
- A strong desire or urge to use a particular substance.

The DSM-5 abandons the distinct criteria of abuse and dependence and introduces a continuum of substance abuse disorder with severity ranked from mild, moderate or severe based on the number of criteria met.
In recent years emerging knowledge has come from neuroscience and the study of the brain in relation to addiction. While a unique genetic vulnerability has still to be identified there is emerging scientific discoveries being made in this area. The combination of potential genetic vulnerability and environment, where people places and things introduce a person to substances is the most likely combination that can lead to addiction.

This diagram shows the circuits involved in drug abuse and addiction.

The reward centre of the brain is what generates the experience of pleasure.

The inhibitory control centre and motivational drive centres are connected with the ability to resist impulsive decisions and weigh up the effects of choices.

The memory/learning centre stores learnt experiences of people, places and things where substance misuse has been made normal by others or experienced.

All of these brain regions must be considered in developing strategies to effectively treat addiction.
DSM-5 criteria

The following lists of criteria are quoted from the DSM-5. We have quoted them in full because the DSM-5 is the official framework in which substance use and addiction are considered and applied in the sector. The rest of the workbook goes on to look at the specifics of different addictions, and how they sit within this framework.

Criteria for substance use disorder

Substance dependence has a cluster of cognitive, behavioural and physiological symptoms, indicating that the person continues use of the substance despite significant substance-related problems. The DSM-5 definition is:

A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following 11 occurring within a 12 month period.

1. A substance is often taken in larger amounts or over a longer period than was intended.
2. There is persistent desire or unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use substances or recover from its effects.
4. Craving or a strong desire or urge to use a substance.
5. Recurrent substance use resulting in the failure to fulfil major role obligations at work, school or home.
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by substance use.
7. Important social, occupational or recreational are given up or reduced because of substance use.
8. Recurrent substance use in situations which are physically hazardous.
9. Substance use is continued despite knowledge of having a recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
   i. A need for markedly increased amounts of a substance to achieve intoxication or desired effect.
   ii. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for a substance
   b. Alcohol or a closely related substance such as a benzodiazepine is taken to relieve or avoid withdrawal symptoms.

Early remission is specified where after a diagnosis of substance use disorder (SUD) has been met none of the criteria for SUD are met for more than 3 but less than 12 months.
Sustained remission is specified where after a diagnosis of substance use disorder has been met none of the criteria for SUD are met for more than 12 months.

**Severity is indicated by:**
- Mild: Presence of 2-3 symptoms
- Moderate: Presence of 4-5 symptoms
- Severe: Presence of 6 or more symptoms (DSM-5, 2013, p490-91)

**Facts and effects of common substances**

There are many drugs available in New Zealand. For the purposes of this learning, commonly used substances will be prioritised. Substances can be described in a variety of ways, and in this workbook, here is how we have grouped them:

- **A** Depressants – alcohol, inhalants
- **B** Stimulants – nicotine, methamphetamine
- **C** Cannabis and synthetic cannabis products
- **D** Opioids
- **E** Hallucinogens and phencyclidines – LSD, PCP, ecstasy

This chart gives an indication of the kind of “highs” and “lows” that coincide with the various types of drugs.

**Intoxication and post-intoxication/withdrawal effects from drugs**

<table>
<thead>
<tr>
<th></th>
<th>Intoxication</th>
<th>Post-intoxication/withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depressants</strong></td>
<td>• Relaxed euphoria</td>
<td>• Agitated dysphoria</td>
</tr>
<tr>
<td><strong>Stimulants</strong></td>
<td>• Energized euphoria</td>
<td>• Retarded dysphoria</td>
</tr>
<tr>
<td><strong>Cannabis</strong></td>
<td>• Meaningful bliss</td>
<td>• Bored irritability</td>
</tr>
<tr>
<td><strong>Opioids</strong></td>
<td>• Warm “heaven”</td>
<td>• Cold “hell”</td>
</tr>
<tr>
<td><strong>Hallucinogens</strong></td>
<td>• Vivid high</td>
<td>• Drab low</td>
</tr>
</tbody>
</table>
Depressants

Alcohol: facts and effects

Alcohol is the primary drug used in New Zealand with over 80% of New Zealand adults drinking at least occasionally. It is a legal drug with ethanol as its main psychoactive ingredient. From the 2007/08 New Zealand Alcohol and Drug Use Survey by the Ministry of Health (MoH), populations at increased risk are younger people, Māori, Pacific men and people living in more deprived neighbourhoods.

Alcohol is:

- Water and fat soluble.
- Rapidly absorbed, reaching peak blood concentration on average in about 45 minutes.
- A central nervous system depressant.
- A drug which affects cognition, mood and behaviour.

Effects will be influenced by:

- The alcohol content of the drink.
- How rapidly the drink is consumed.
- The addition of food or other drugs.
- Specific characteristics of the person, such as age, size, gender and previous exposure to alcohol (“tolerance”).

Measuring the alcohol we drink

The Alcohol Advisory Council (ALAC) website www.alac.org.nz has advice on standard drinks.

*Alcohol is measured in a unit called a standard drink (SD). One SD is equivalent to 10 grams of pure alcohol.*

Alcohol amount in a drink is often given as a percentage of the volume, for example a can of beer might be 4–5% alcohol and wine can be 12–14.5%.
### An easy way to measure the alcohol we drink

<table>
<thead>
<tr>
<th>Drink Type</th>
<th>Alcohol Content</th>
<th>Alcohol Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x regular 330 ml can of beer (4%)</td>
<td>10g pure alcohol</td>
<td>1 x 330 ml</td>
</tr>
<tr>
<td>1 x 100 ml glass of wine (12%)</td>
<td>10g pure alcohol</td>
<td>1 x 100 ml</td>
</tr>
<tr>
<td>1 x 60 ml glass of fortified wine (21%) (sherry/port)</td>
<td>10g pure alcohol</td>
<td>1 x 60 ml</td>
</tr>
<tr>
<td>1 x 30 ml (nip) of spirits (42%)</td>
<td>10g pure alcohol</td>
<td>1 x 30 ml</td>
</tr>
</tbody>
</table>

### Alcohol in standard drinks

<table>
<thead>
<tr>
<th>Drink Type</th>
<th>Alcohol Content</th>
<th>Alcohol Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 x 750 ml bottle of beer (4%)</td>
<td>2.4 SD</td>
<td>1 x 750 ml</td>
</tr>
<tr>
<td>1 x 750 ml bottle of wine (12%)</td>
<td>7.1 SD</td>
<td>1 x 750 ml</td>
</tr>
<tr>
<td>1 x 3 litre cask of wine (12.5%)</td>
<td>30 SD</td>
<td>1 x 3 litre</td>
</tr>
<tr>
<td>1 x 375 ml bottle of spirits (37.5%)</td>
<td>11 SD</td>
<td>1 x 375 ml</td>
</tr>
<tr>
<td>1 x 1125 ml bottle of spirits (45%)</td>
<td>40 SD</td>
<td>1 x 1125 ml</td>
</tr>
</tbody>
</table>

### Alcohol (SD) in ready to drink (RTD) beverages.

<table>
<thead>
<tr>
<th>Drink Type</th>
<th>Alcohol Content</th>
<th>Alcohol Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 can 440 mls premix bourbon 7% (1.7 SD)</td>
<td>1.7 SD</td>
<td>1 can 440 ml</td>
</tr>
<tr>
<td>1 x 4 pack Vodka Ice 7% (7.6 SD)</td>
<td>7.6 SD</td>
<td>1 x 4 pack</td>
</tr>
</tbody>
</table>
Drinking without health or other problems

- See alcohol.org.nz for the new low risk guidelines. These have changed from being called safe limits.

Reduce your long-term health risks by drinking no more than:

- **two** standard drinks **a day for women** and no more than **10** standard drinks **a week**.
- **three** standard drinks **a day for men** and no more than **15** standard drinks **a week**.

AND at least **two alcohol-free days** every week.

Reduce your risk of injury of drinking by drinking on a single occasion no more than:

- **four** standard drinks **for women** on any **single occasion**.
- **five** standard drinks **for men** on any **single occasion**.

Advice for women about pregnancy and drinking

Women who might be pregnant, are pregnant, or are planning to get pregnant

There is no known safe level of alcohol use at any stage of pregnancy.

- Advice for parents of children and young people under 18 years
- For children and young people under 18 years, not drinking alcohol is the safest option.
- Those under 15 years of age are at the greatest risk of harm from drinking alcohol and not drinking in this age group is especially important.
- For young people aged 15 to 17 years, the safest option is to delay drinking for as long as possible.
- If 15 to 17 year olds do drink alcohol, they should be supervised, drink infrequently and at levels usually below and never exceeding the adult daily limits.
Tips for low-risk drinking

It is possible to drink at a level that is less risky, while still having fun. There are a number of things you can do to make sure you stay within low-risk levels and don't get to a stage where you are no longer capable of controlling your drinking.

These include:

- know what a standard drink is.
- keep track of how much you drink - daily and weekly.
- set limits for yourself and stick to them.
- start with non-alcoholic drinks and alternate with alcoholic drinks.
- drink slowly.
- try drinks with a lower alcohol content.
- eat before or while you are drinking.
- never drink and drive.
- be a responsible host.
- talk to your kids about alcohol.

These low risk levels are not recommended for anyone whose health or safety can be further compromised through drinking alcohol. Abstinence may therefore be more appropriate for:

- Those who have a medical condition made worse by alcohol, for example, diabetes or liver disease.
- Those on medication which interacts with alcohol, like benzodiazepines or opioids.
- Women who are pregnant (there are no "safe levels" of drinking in pregnancy).
- People who are driving, taking risks or operating complex machinery.
- Young, frail or elderly people.

Current legal limits of alcohol concentration (driving)

There are two ways of assessing the alcohol limit for driving. Although the measures appear different, they both measure the same level of alcohol for drink-driving purposes.

The legal limits depend upon the age of the person.

Over 20 years old:
- 250mcg breath – 250 micrograms of alcohol (mcgs) per litre of breath  OR
- 50mg blood – 50 milligrams of alcohol (mgs) per 100 millilitres (mls) of blood.

For under 20 years old, the drink-driving limits have been reviewed down to zero.
Signs of alcohol use

<table>
<thead>
<tr>
<th>Low to moderate levels of alcohol consumption</th>
<th>Higher levels of alcohol consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stimulation.</td>
<td>• Behaving out of character.</td>
</tr>
<tr>
<td>• Smell of alcohol.</td>
<td>• Mood swings.</td>
</tr>
<tr>
<td>• Some disinhibition.</td>
<td>• Emotions exaggerated.</td>
</tr>
<tr>
<td>• Reduced concentration and memory.</td>
<td>• Lower tolerance, irritability.</td>
</tr>
<tr>
<td>• Impaired judgement.</td>
<td>• Communication affected.</td>
</tr>
<tr>
<td>• Reduced perception of distance, space and time.</td>
<td>• Memory blackouts.</td>
</tr>
<tr>
<td>• Reduced reaction time, reduced co-ordination, slurred speech.</td>
<td>• Vomiting.</td>
</tr>
<tr>
<td>• Increased passing of urine.</td>
<td>• Uncoordinated in movements.</td>
</tr>
<tr>
<td></td>
<td>• Drowsiness.</td>
</tr>
<tr>
<td></td>
<td>• Respiratory depression.</td>
</tr>
<tr>
<td></td>
<td>• Constricted pupils.</td>
</tr>
<tr>
<td></td>
<td>• Flushing or perspiring (withdrawal).</td>
</tr>
</tbody>
</table>

DSM-IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each. DSM-5 integrates these into a single alcohol use disorder (AUD) with mild, moderate and severe classifications, depending upon the number of criteria met. While the overall number of criteria remain at eleven, craving has been added in the DSM-V and the criteria around being arrested or having legal problems has been dropped.

Criteria for alcohol intoxication

A  Recent ingestion of alcohol.

B  Clinically significant problematic behaviour or psychological changes (e.g. inappropriate sexual or aggressive behaviour, mood lability, impaired judgement) that developed during or shortly after alcohol ingestion.

C  One of more of the following signs or symptoms developing during or shortly after alcohol use; slurred speech, incoordination, unsteady gait, nystagmus (involuntary eye movement), impairment in attention or memory, stupor or coma.

D  The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder including intoxication with another substance including intoxication from another substance.
Criteria for alcohol withdrawal

A  Cessation of (or reduction in) alcohol use that has been heavy and prolonged.

B  Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in Criterion A.
   i  Autonomic hyperactivity (e.g. sweating or pulse rate greater than 100 bpm).
   ii Increased hand tremor.
   iii Insomnia.
   iv Nausea or vomiting.
   v  Transient visual, tactile or auditory hallucinations or illusions.
   vi Psychomotor agitation.
   vii Anxiety.
   viii Generalised grand mal seizures.

C  The signs or symptoms in Criteria B clause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D  The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder including intoxication or withdrawal from another substance.

Common names
Booze, juice, sauce, grog, piss, turps.
### A Comparison Between DSM-IV and DSM-5

<table>
<thead>
<tr>
<th>DSM-IV</th>
<th>DSM-5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the past year, have you:</strong></td>
<td><strong>In the past year, have you:</strong></td>
</tr>
<tr>
<td>Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?</td>
<td>Had times when you ended up drinking more, or longer, than you intended?</td>
</tr>
<tr>
<td>More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?</td>
<td>More than once wanted to cut down or stop drinking, or tried to, but couldn’t?</td>
</tr>
<tr>
<td>More than once gotten arrested, been held at a police station, or had other legal problems because of your drinking?</td>
<td>Spent a lot of time drinking? Or being sick or getting over other aftereffects?</td>
</tr>
<tr>
<td><strong>&quot;This is not included in DSM-5&quot;</strong></td>
<td>Wanted a drink so badly you couldn’t think of anything else?</td>
</tr>
<tr>
<td><strong>&quot;This is not included in DSM-5&quot;</strong></td>
<td>Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?</td>
</tr>
<tr>
<td>Continued to drink even though it was causing trouble with your family or friends?</td>
<td>Continued to drink even though it was causing trouble with your family or friends?</td>
</tr>
<tr>
<td><strong>Any 1 = ALCOHOL ABUSE</strong></td>
<td><strong>The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD).</strong></td>
</tr>
<tr>
<td><strong>Any 3 = ALCOHOL DEPENDENCE</strong></td>
<td>The severity of the AUD is defined as:</td>
</tr>
<tr>
<td>Had to drink much more than you once did to get the effect you wanted? Or found that your usual number of drinks had much less effect than before?</td>
<td>Mild: The presence of 2 to 3 symptoms</td>
</tr>
<tr>
<td>Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?</td>
<td>Moderate: The presence of 4 to 5 symptoms</td>
</tr>
<tr>
<td><strong>Any 3 = ALCOHOL DEPENDENCE</strong></td>
<td>Severe: The presence of 6 or more symptoms</td>
</tr>
<tr>
<td>Had times when you ended up drinking more, or longer, than you intended?</td>
<td>Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?</td>
</tr>
<tr>
<td>More than once wanted to cut down or stop drinking, or tried to, but couldn’t?</td>
<td>More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?</td>
</tr>
<tr>
<td>Spent a lot of time drinking? Or being sick or getting over other aftereffects?</td>
<td>Continued to drink even though it was making you depressed or anxious or adding to another health problem? Or after having had a memory blackout?</td>
</tr>
<tr>
<td>Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?</td>
<td>Had to drink much more than you once did to get the effect you wanted? Or found that your usual number of drinks had much less effect than before?</td>
</tr>
<tr>
<td>Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?</td>
<td>Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?</td>
</tr>
</tbody>
</table>
Inhalants: facts and effects

Solvents are:
- Liquid chemical compounds that release vapours in air at ordinary temperatures.
- Central nervous system depressants.
- Sniffed deliberately out of containers by users to cause intoxication.
- Huffed from saturated material or clothing held up to nose or mouth.
- Inhaled from bags held over mouth and nose (bagging).
- Used by younger age groups (most prevalent are males 14 to 20 years).
- More easily available and less expensive than most other drugs.
- Fat soluble.

Common types of solvents used are petrol and lighter fluid, paint thinners, lacquer, varnish, glues and adhesives, correcting fluid, dry cleaning products, nail polish and nail polish remover, and aerosols like spray paints, hair and insect sprays and air freshener.

Some groups more likely at risk from inhalant use are:
- Adolescents experimenting with drugs.
- Young adolescent drug users with less access to money, eg "street kids".
- Young people associating with volatile substance users.
- From the 2007/08 New Zealand Alcohol and Drug Use Survey (MoH), males are more likely to use than females and there is increased use with neighbourhood deprivation. Approximately 2% of the population have used inhalants.

**Signs of solvent use**

<table>
<thead>
<tr>
<th>Lower doses</th>
<th>Higher doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euphoria.</td>
<td>Solvents displace oxygen, so can cause loss of consciousness and blackouts, brain and lung damage; also risks of liver and kidney damage.</td>
</tr>
<tr>
<td>Excitement, exhilaration.</td>
<td>Asphyxiation/suffocation can occur from inhaling vomit (from bags) or from substances in the mouth during huffing.</td>
</tr>
<tr>
<td>Feelings of invulnerability, strength.</td>
<td>Birth malformations can occur with pregnant users.</td>
</tr>
<tr>
<td>Slurred speech.</td>
<td>Sudden death can occur from heart complications.</td>
</tr>
<tr>
<td>Confusion, disorientation.</td>
<td>Common names Glue, gas, sniff, huff, chroming (as in the use of chrome paint).</td>
</tr>
</tbody>
</table>
Stimulants

Nicotine: facts and effects

Tobacco is the second most commonly used drug in New Zealand. Although tobacco use is reducing overall in New Zealand, approximately 21% of the population over 15 years smoke in varying amounts. Māori, Pacific and people living in the most deprived neighbourhoods are at increased risk. Tobacco is the largest cause of preventable death in New Zealand with half of its users dying from it, shortening their lifespan by about 15 years. Tobacco contains 4,000 chemicals, of which 60 are carcinogenic, and one in every four deaths from cancer is caused by tobacco smoking. The Smoke-free Environments Amendment Act 2003 came into effect as a result of such statistics.

The primary effect of nicotine is arousal and this is facilitated by release of dopamine, norepinephrine and serotonin, which provides behavioural reinforcement, stimulant and antidepressant actions for the user, when smoking, smelling, chewing, or using patches. Nicotine abuse is not in the DSM as nicotine users are physically dependent on the drug.

The positive effects of smoking include:
- Increase in clear thinking and concentration.
- Enhanced performance in visual surveillance.
- Increase in rapidity of information processing.
- Enhanced recall.

The negative effects of smoking include:
- Reduced appetite.
- Nausea, vomiting.
- Respiratory irritation.
- Increased cancer risk.
- Hypertension, increased heart rate.
The DSM-V has included tobacco for the first time.

**Tobacco Use Disorder**

A problematic pattern of tobacco use leading to clinically significant impairment or distress, as manifested by at least two of the following occurring within a 12 month period.

1. Tobacco is often taken in larger amounts or over a longer period than was intended.
2. There is persistent desire or unsuccessful efforts to cut down or control tobacco use.
3. A great deal of time is spent in activities necessary to obtain tobacco, use tobacco or recover from its effects.
4. Craving or a strong desire or urge to use tobacco.
5. Recurrent tobacco use resulting in the failure to fulfil major role obligations at work, school or home.
6. Continued tobacco use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by tobacco use.
7. Important social, occupational or recreational areas are given up or reduced because of tobacco use.
8. Recurrent tobacco use in situations which are physically hazardous (e.g. smoking in bed).
9. Tobacco use is continued despite knowledge of having a recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
   i. A need for markedly increased amounts of a tobacco to achieve intoxication or desired effect.
   ii. A markedly diminished effect with continued use of the same amount of the tobacco.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for tobacco.
   b. Tobacco or a closely related substance such as nicotine is taken to relieve or avoid withdrawal symptoms.

**Tobacco Withdrawal**

A Daily use of nicotine for at least several weeks.
B Abrupt cessation of nicotine use, or reduction in the amount of nicotine used, followed within 24 hours by four (or more) of the following signs:
1. Dysphoric or depressed mood.
2. Insomnia.
3. Irritability, frustration, or anger.
4. Anxiety.
5. Difficulty concentrating.
6. Restlessness.
7. Decreased heart rate.
   Increased appetite or weight gain.
Amphetamines: facts and effects

Stimulants (or psychostimulants) are drugs that stimulate the central nervous system, and the main examples are amphetamines and cocaine. Amphetamines are synthetic drugs that are similar to naturally occurring substances like adrenaline and ephedrine. Methamphetamine (a derivative) is more potent, more addictive and therefore potentially more harmful than amphetamines. Cocaine has a shorter “half-life” and duration of action than amphetamines. Both amphetamines are Class A drugs.

According to the Drug Use in New Zealand Survey 2007/2008, one in ten have used a stimulant (amphetamines, cocaine, prescription stimulants) for recreational purposes at some point in their lifetime. Māori and European Pākehā are the highest users of stimulant drugs.

The 2012/13 New Zealand Health Survey (NZHS) presents findings about amphetamine use. It reports ‘at least monthly’ and ‘past year’ amphetamine use in adults aged 16–64 years of age. It also reports the mean age of ‘past year’ amphetamine users aged 16–64 years of age. Data was self-reported and collected from 1 July 2012 to 30 June 2013.

In 2012/13, 0.2 percent of New Zealand adults aged 16–64 years reported having used amphetamines at least monthly and 0.9 percent reported having used amphetamines in the past year. The mean age of ‘past year’ amphetamine users among New Zealanders aged 16–64 years was 29 years.

After adjusting for age, the prevalence of ‘past year’ amphetamine use declined from 2003 (2.7 percent) to 2012/13 (0.9 percent) for 16–64 year olds. However, there was no significant difference in the prevalence of ‘past year’ amphetamine use between 2011/12 and 2012/13.

Psychostimulants:
- Concentrate in the brain, lungs and kidneys.
- Are metabolised by the liver and excreted by the kidneys.
- Stimulate neurotransmitter release and prevent reuptake.
- Have uses for treating obesity, uncontrolled sleep, ADHD (attention deficit hyperactivity disorder – Ritalin).
- Are used recreationally to increase stamina, performance and confidence.
- Can last in the system for 12–36 hours (amphetamine); 8–17 hours (methamphetamine).
- Are increasingly being used in New Zealand.
- Can be taken orally, smoked, snorted or injected.
Common types of psychostimulants are:
- Cocaine (usually snorted).
- Crack cocaine (usually smoked).
- Speed (amphetamine sulphate/hydrochloride).
- Methamphetamine tablets.
- Crystal meth (usually smoked).
- Methamphetamine base (moist, oily yellow to brown substance).
- “P” (pure) – refers to the purity and strength of the drug.

It is difficult to estimate dosage in powdered, crystal or base forms, as different means of manufacturing mean that drug quality and purity can vary and it is too hard to tell through appearance, smell or taste. Therefore, overdose can be a concern, especially in new users, and particularly when snorting.

Effect of P – “tweaking” – used repeatedly for days with no sleep or food, causing steep crash (this is the most violent and unpredictable state).

Some groups more at risk from using psychostimulants include:
- Young people (wanting confidence and stamina for parties and raves).
- Some occupational groups (wanting the energy and stamina for extended and/or late night shifts or study).
- People on other drugs (seeking better highs, different effects).
- Risk-takers (wanting greater confidence – but may result in over-confidence, misjudging of skills and abilities).
- Those driving or operating machinery (may result in over-confidence, increased risk-taking and accidents).
- Those with a personal or family history of psychiatric disorder (risk of psychosis).
**Signs of stimulant use**

<table>
<thead>
<tr>
<th>Lower doses</th>
<th>Higher doses</th>
<th>Physical problems</th>
</tr>
</thead>
</table>
| • Euphoria or high (a “rush”).  
• Increased alertness, energy, talkativeness, improved performance.  
• Sense of confidence, wellbeing.  
• Increased libido.  
• Reduced appetite.  
• Hallucinations.  
• Impaired speech.  
• Teeth grinding.  
• Reduced fatigue/need for sleep.  
• Dilated pupils.  
• Dizziness.  
• Headache.  
• Restless, irritable, apprehensive.  
• “Crawling” sensation on skin. | • Rapid, pressured or slurred speech.  
• Mood swings, unpredictable, violent behaviour.  
• Paranoid thoughts or confusion.  
• Psychosis (hallucinations, delusions).  
• Distorted body image.  
• Depression, suicidal thoughts. | • Nausea/vomiting.  
• Dry mouth.  
• Heart problems, heart attack.  
• Respiratory problems.  
• Seizures. |

**DSM-5 Withdrawal criteria**

A Cessation of (or reduction in) prolonged amphetamine type substance, cocaine or other stimulant use.

B Dysphoric (unhappy) mood and two (or more) of the following physiological changes, developing within a few hours to several days:

1 Fatigue.
2 Vivid, unpleasant dreams.
3 Insomnia or hypersomnia.
4 Increased appetite.
5 Psychomotor retardation or agitation.

**Common names**

**Amphetamines:** speed, go-ey, whiz.

**Methamphetamine:** speed, meth, pure or P, chalk, crank, crystal, ice, glass, crystal meth, sketch, go, junk, wake-up, zoom, tweak, dope, goey.

**Cocaine:** C, coke, flake, nose candy, snow, dust, white, white lady, toot, crack, rock or freebase.
Cannabis

Facts and effects

The 2012/13 New Zealand Health Survey (NZHS) provides valuable information about cannabis use by adults aged 15 years and over. It builds upon and adds value to the findings of the 2007/08 New Zealand Alcohol and Drug Use Survey report on cannabis.

This report presents information on cannabis use in New Zealand, including patterns of use, drug-driving, harms from use (productivity and learning, and mental health), legal problems, and cutting down and seeking help. Information on the medicinal use of cannabis is also presented.

Patterns of cannabis use

Eleven percent of adults aged 15 years and over reported using cannabis in the last 12 months (defined here as cannabis users). Cannabis was used by 15% of men and 8.0% of women. Māori adults and adults living in the most deprived areas were more likely to report using cannabis in the last 12 months. Thirty-four percent of cannabis users reported using cannabis at least weekly in the last 12 months. Male cannabis users were more likely to report using cannabis at least weekly in the last 12 months.

Cannabis and driving

Thirty-six percent of cannabis users who drove in the past year reported driving under the influence of cannabis in the last 12 months. Men were more likely to have done so.

Cannabis-related learning and productivity harms

Six percent of cannabis users reported harmful effects on work, studies or employment opportunities, 4.9% reported difficulty learning, and 1.7% reported absence from work or school in the last 12 months due to cannabis use.

Cannabis and mental health harms

Eight percent of cannabis users reported a time in the last 12 months that cannabis use had a harmful effect on their mental health. Younger cannabis users (aged 25–34 years) were most affected, with reported harm to mental health decreasing markedly by age 55+ years.
Cannabis and legal problems

Two percent (2.1%) of cannabis users reported experiencing legal problems because of their use in the last 12 months.

Cutting down and help to reduce cannabis use

Most cannabis users (87%) did not report any concerns from others about their use. Seven percent of cannabis users reported that others had expressed concern about their drug use or had suggested cutting down drug use within the last 12 months. Of cannabis users, 1.2% had received help to reduce their level of drug use in the last 12 months. Few cannabis users who wanted help did not get it (3.6%).

Cannabis use for medicinal purposes

Forty-two percent of cannabis users reported medicinal use (ie, to treat pain or another medical condition) in the last 12 months. Rates were similar for men and women. Older cannabis users (aged 55+ years) reported higher rates of medicinal use.

Cannabis in all its forms is derived from the plant cannabis sativa and is the most widely used illicit drug in New Zealand. In New Zealand, 46% of the adult population have used it at some point (MoH, 2010). The main psychoactive ingredient is delta-9-tetrahydrocannabinol (THC) and is fat soluble, so that cannabis metabolites are much more slowly eliminated from the body and can be measured in urine samples days or even weeks after cessation of the drug, depending on heaviness and duration of use. In moderate doses, cannabis has stimulant and analgesic actions and, like alcohol, can act as a central nervous system depressant. In higher doses it has a mild hallucinogenic effect and can be associated with increased occurrences of psychosis. Cannabis cultivation, possession, use and sale are all illegal in New Zealand and there are legal sanctions against activities relating to its use. Cannabis oil and hashish are Class B drugs and cannabis seed and plant are Class C drugs.

Cannabis is most often consumed by:

- Smoking joints (leaves and heads of plants).
- Smoking with tobacco.
- In water pipes (bongs).
- Burning hash/resin or oil (concentrated extracts).
- Eating it in food or drinking in a tea (slower to take effect but lasts longer).
Cannabis dosage is hard to measure, since this will vary according to quality and strength of the part of the plant used, for example, flower heads of the female plants are stronger than leaves and stems, which are mixed in marijuana. Also, the strength of cannabis has generally increased over time with improved cultivation methods.

Concentrated cannabis products like oil and hash/resin contain a more powerful dose. However, cannabis use is not associated with fatal overdose. Generally speaking, occasional recreational use (less than 1 joint per week) is not associated with harmful effects.

Regular users (3–4 joints per week) may find that they start to build up a residual level of cannabinoids in their system, as metabolites are not eliminated before the next dose. Heavier users (daily use to several joints per day or regular use of concentrated products) will likely experience negative health and social effects over time.

Some groups are more likely to suffer negative effects from regular use of cannabis, and these include:

- Adolescents (more likely to interfere with normal psychosocial development).
- Pregnant women (regular smoking may have negative effects on the foetus).
- Those with respiratory or cardiac problems (can exacerbate the condition).
- Those vulnerable to psychosis (eg people with or at risk of schizophrenia).

### Signs of cannabis use

<table>
<thead>
<tr>
<th>Low to moderate levels of cannabis consumption</th>
<th>Higher doses and long term heavy use of cannabis consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Red eyes.</td>
<td>• Hallucinations.</td>
</tr>
<tr>
<td>• Disinhibition, talkativeness, spontaneous laughter.</td>
<td>• Disorganised, confused thoughts, feeling of unreality.</td>
</tr>
<tr>
<td>• Relaxed, drowsy, laid back.</td>
<td>• Confusion of past and future.</td>
</tr>
<tr>
<td>• Apathy, lack of energy.</td>
<td>• Impaired judgement.</td>
</tr>
<tr>
<td>• Sense of wellbeing or euphoria.</td>
<td>• Paranoia, suspicion</td>
</tr>
<tr>
<td>• Enhanced perceptions (visual, auditory, tactile).</td>
<td>• Anxiety.</td>
</tr>
<tr>
<td>• Reduced memory, concentration and focus.</td>
<td>• Psychological dependence.</td>
</tr>
<tr>
<td>• Distorted perception of time.</td>
<td>• Cognitive impairment (may be reversible).</td>
</tr>
<tr>
<td>• Increased appetite (“the munchies”).</td>
<td>• Respiratory damage.</td>
</tr>
<tr>
<td>• Dry mouth/throat.</td>
<td>• Increased cancer risk (smoking).</td>
</tr>
<tr>
<td>• Reduced ability to accomplish complex tasks (driving/operating machinery).</td>
<td>• Reduced sperm count.</td>
</tr>
<tr>
<td></td>
<td>• Apathy and social withdrawal in some individuals.</td>
</tr>
</tbody>
</table>
Some benefits
AIDS – cannabis can stimulate the appetite of AIDS sufferers.
Cancer – cannabis can reduce nausea arising from chemotherapy.
Glaucoma – cannabis reduces pressure.
Multiple sclerosis – cannabis reduces involuntary movement.
Chronic pain – cannabis can reduce pain.

Cannabis withdrawal
Cannabis withdrawal is included in the DSM-V.
It includes
A Cessation of cannabis use that has been heavy and prolonged (i.e. usually daily or almost daily over a period of at least a few months)
B Three (or more) of the following signs and symptoms develop within approximately 1 week after criterion A:
   1 Irritability anger or aggression.
   2 Nervousness or anxiety
   3 Sleep difficulty (e.g. insomnia, disturbing dreams)
   4 Decreased appetite of weight loss
   5 Restlessness
   6 Depressed mood
   7 At least one of the following physical symptoms causing significant discomfort, abdominal pain, shakiness/tremors, sweating, fever, chills or headache
C The signs or symptoms in criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder during intoxication or withdrawal from another substance.

Common names
Pot, grass, dope, hooch, herb, weed, dak, tinnies. Tinnies (1.5 grams approx, wrapped in tinfoil) are used for dealing in small quantities.
Opioids

Facts and effects

Opioid drugs act on the opioid receptor system and are primarily prescribed for use as narcotic analgesics, for severe pain. The most common drug in this category in New Zealand is morphine. According to the latest Drug Use in New Zealand Survey 2007/2008, 3.6 percent of 16 to 64 year olds have used opiates recreationally.

Morphine

- Class B drug.
- Commonly prescribed as an oral medication (morphine sulphate tablets eg for cancer patients).
- Usually injected by drug users.
- Occasionally smoked.

Codeine

- Class C drug.
- A narcotic analgesic prescribed for mild to moderate pain.
- A cough suppressant (in cough syrups).
- Treatment for diarrhoea.
- Taken orally, effects last 3–4 hours.

Home-bake

- Codeine based, often extracted from over the counter analgesics like panadeine.
- Usually injected.
- Quality and dosage will vary according to the skill of the person “baking” and what other substances may be mixed with the codeine.
- A NZ response to the lack of other easily available commercial opioids.

Poppies

- From the opium poppy (easily grown in New Zealand).
- Bled from seed pod and “cooked”.
- Usually injected.
- Effects similar to morphine and heroin.
- Intravenous users usually experience a “rush” (an intense orgasmic-like reaction) soon after injecting, and euphoric feelings can last up to 3–6 hours.
Temgesic (Buprenorphine)

- Synthetic opioid analgesic.
- Opioid blocker and can be used orally to manage opioid dependence.
- Can be injected but not commonly used recreationally in NZ.

Methadone

- Long acting (24 hours) synthetic opioid analgesic.
- Can be used in treatment of chronic pain.
- Can be injected by drug users.
- Opioid blocker, stops craving for other opioids.
- Methadone programmes are the most usual treatment for opioid dependence.
- Taken orally (syrup) daily, on pharmacy premises.
- “Takeaways” given by arrangement on holidays.
- “GP care” now common, less AOD clinic time required.
- Avoids all harms associated with needle use (HIV, hepatitis B and C, needle site damage, criminal activity, drug seeking, etc.) and allows for stability.

Heroin

- Class A drug.
- Derived from morphine, with similar action.
- Available as a white soluble powder.
- Usually injected.
- Can be smoked or snorted.
- Less available in New Zealand than other countries such as Australia and the UK.

### Signs of opioid use

<table>
<thead>
<tr>
<th>Feelings of euphoria.</th>
<th>Possible nausea/vomiting.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drowsiness, lethargy.</td>
<td>Dry mouth.</td>
</tr>
<tr>
<td>Reduced sensations and response to pain.</td>
<td>Loss of appetite.</td>
</tr>
<tr>
<td>Reduced concentration.</td>
<td>Constipation and/or difficulty urinating.</td>
</tr>
<tr>
<td>Pupils constricted (“pinned” pupils).</td>
<td>Reduced cough reflex.</td>
</tr>
<tr>
<td>Sweating, prickly or itchy skin.</td>
<td>Loss of libido.</td>
</tr>
<tr>
<td>Needle tracks on arms/legs.</td>
<td></td>
</tr>
</tbody>
</table>

The sharing of needles may lead to infection with hepatitis B, hepatitis C (common), or HIV. Clean needle use is encouraged through needle exchange programmes.
DSM–5 Withdrawal criteria

A  Presence of either of the following
   1  Cessation of (or reduction in) opioid use that has been heavy and prolonged
      (i.e. several weeks or longer)
   2  Administration of an opioid antagonist after a period of opioid use.

B  Three (or more) of the following, developing within minutes to several days:
   1  Nausea or vomiting.
   2  Muscle aches.
   3  Lacrimation or rhinorrhea (tears or runny nose).
   4  Pupillary dilation, piloerection (“goose bumps”), or sweating.
   5  Diarrhoea.
   6  Yawning.
   7  Fever.
   8  Insomnia.

Common names
Morph, mistys, smack, scag, dope, H, junk, hammer, slow, gear, harry, shit, horse.
Hallucinogens

Facts and effects

Although a number of drugs can produce hallucinations, there are several drugs which are used specifically for this purpose. These may be synthetically produced or derived from plant sources, taken orally and are less likely to cause dependence because of their irregular pattern of use. They are considered Class A drugs.

LSD (Lysergic Acid Diethylamide)

- A synthetic high potency drug.
- Taken in the form of tablets, capsules, solution or on a medium, like blotting paper.
- Used for hallucinations, changes in perception, changes in senses.
- 7.3 percent of 16 to 64 year olds have used LSD. (Source: Drug Use in New Zealand Survey 2007/2008)
- Not currently in common use in New Zealand.

Mushrooms, “magic mushrooms” (psilocybin)

- Available in New Zealand usually in season (early autumn).
- Can be eaten fresh.
- Dried or powdered in capsules or mixed in solution.

Cactus/Peyote (mescaline)

- Is a naturally occurring hallucinogen from the peyote cactus (Mexico and US).
- Can also be synthesised.
- Can be taken orally or dried and smoked.

Signs of hallucinogen use

- Dilated pupils.
- Impaired coordination.
- Exhilaration.
- Hallucinations, illusions.
- Numbness, cramps, nausea/vomiting.
- Muscle twitching, rapid reflexes.
- Distortion of time and space, past and present, boundaries between self and environment.
- Decreased concentration.
- Heightened senses.
- In a bad trip – withdrawal, anxiety, depression, paranoia, terrifying hallucinations, bizarre delusions.
- Flashbacks to experiences in a bad trip, re-experiencing anxiety and/or panic.
Other hallucinogens

PCP (phencyclidine) “angel dust”
An hallucinogen with differing signs of intoxication. PCP is:
- A central nervous system stimulant.
- A depressant and analgesic.
- Used for veterinary purposes.
- A white powder (pharmaceutically) taken as pills, injected or smoked.
- Known for undesirable effects such as aggression and psychosis.

Signs of use of other hallucinogens

<table>
<thead>
<tr>
<th>Lower doses</th>
<th>Higher doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Euphoria.</td>
<td>• Involuntary eye movement.</td>
</tr>
<tr>
<td>• Relaxation, dissociation, drowsiness.</td>
<td>• Anxiety, panic, terror.</td>
</tr>
<tr>
<td>• Speech and attention deficits.</td>
<td>• Paranoia, psychosis.</td>
</tr>
<tr>
<td>• Distortion in body image, time space.</td>
<td>• Erratic, bizarre, aggressive behaviour.</td>
</tr>
<tr>
<td>• Sensory distortions.</td>
<td>• Anaesthesia, respiratory depression.</td>
</tr>
<tr>
<td>• Loss of coordination.</td>
<td>• Stupor, coma, convulsions.</td>
</tr>
<tr>
<td>• Pupil constriction, blurred vision.</td>
<td></td>
</tr>
<tr>
<td>• Sweating, nausea/vomiting.</td>
<td></td>
</tr>
</tbody>
</table>

Ecstasy
- Ecstasy is MDMA – methylene dioxyamphetamine
- Class B stimulant and hallucinogen usually 1 or 2 tablets (75–100 mg) are taken at a time, although the drug can be injected, snorted and mixed in a drink.
- Is often used by young people and is known as a party/dance/rave drug and can last for 3 hours.
- Ecstasy speeds up the nervous system, with users becoming alert and talkative. It produces increased alertness and stamina, distorted sense of time and perception, enhanced sensual awareness (visual, auditory and tactile), feeling of euphoria, wellbeing, empathy, love, mental clarity, and appreciation of music and movement.
- It also can lead to dehydration, can increase heart rate, blood pressure and body temperature, and has been known to cause heart attacks, strokes, and kidney failure.
Common names

LSD: acid, trips, tripping.
Mushrooms: golden top, shrooms, liberty caps, blue meanies.
GHB: fantasy, grievous bodily harm, liquid ecstasy, liquid E.
Ketamine: K, special K.
Ecstasy (MDMA): E, XTC, eckie, eccy, the love drug, adam, hug.
Withdrawal criteria

Did you notice that there are no DSM withdrawal criteria for hallucinogens and inhalants?

The DSM-5 acknowledges that withdrawal symptoms may be a feature in these disorders but there is uncertainty about the clinical significance and that more information is needed.

Record what you know about these substances in terms of withdrawal.
LEARNING ACTIVITY

For each indicator choose one of the following drugs:
alcohol, cannabis, P, ecstasy, morphine, glue, mushrooms, nicotine, homebake.

Then identify what type of drug it is, eg depressant, stimulant, hallucinogen, opioid, solvent etc.

The first answer is done for you, in red. Suggested answers are on page 57.

Notes: Some of these indicators are more advanced symptoms of use and some are manifestations of the problem when intoxicated. The absence of some of these does not necessarily indicate there is no problem. The behaviours are often common to more than one substance or activity, but there is usually one more typical and/or defining feature in each group. More than one set is provided for some common substances/activities.

<table>
<thead>
<tr>
<th>Indicators of alcohol and other drug (AOD) problems</th>
<th>Drug name and type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disinhibition, uncoordinated movements, drowsiness, increased absenteeism.</td>
<td>Alcohol – a central nervous system (CNS) depressant.</td>
</tr>
<tr>
<td>Lost interest in things which were important, difficulty with concentration, paranoia and suspicion, mood incongruent to situation (eg inappropriate laughter).</td>
<td></td>
</tr>
<tr>
<td>Intoxication (disinhibited, drowsy); absences, absenteeism, erratic lifestyle; marks/tracks on arms/legs (or purposely covered); frequent periods of sickness or health issues.</td>
<td></td>
</tr>
<tr>
<td>Tired and exhausted, but wide awake; alert and talkative; raves/party lifestyle; absenteeism, especially Mondays after weekend partying.</td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Confusion, disorientation, slurred speech, incoordination, discolouration around mouth.</td>
<td></td>
</tr>
<tr>
<td>Dilated pupils, decreased concentration, out of touch with self and/or environment, flashbacks (re-experiencing anxiety and/or panic)</td>
<td></td>
</tr>
<tr>
<td>Appears “high” or euphoric, overconfident; rapid, pressured or slurred speech; paranoid, aggressive, violent or unpredictable behaviour.</td>
<td></td>
</tr>
<tr>
<td>Frequent brief absences from other activities, respiratory problems, distinctive smell, irritability or agitation when unable to leave situations for long period.</td>
<td></td>
</tr>
<tr>
<td>Impaired judgement, risk-taking, slurred speech, inability to recall previous night’s events, deterioration in relationships.</td>
<td></td>
</tr>
<tr>
<td>Social withdrawal; loss of energy, apathy, relaxed, “laid-back”, drowsy; increased appetite (especially fast foods) – “the munchies”.</td>
<td></td>
</tr>
<tr>
<td>Social withdrawal or isolation; increased offences, legal problems (eg pharmacy robbery); decreased work performance, frequent unemployment; financial problems; deterioration in appearance and/or assets.</td>
<td></td>
</tr>
<tr>
<td>Increased urination; irritable, rigid, intolerant; reduced memory, concentration; stimulated, then drowsy or lethargic.</td>
<td></td>
</tr>
</tbody>
</table>
Effects on addiction service users

Alcohol and other drug addictions can cause many effects on a person, including risky behaviours and consequences related to being addicted to substances. Use the scenarios presented in this section on substance users as a way of integrating the material provided to be able to identify the effects of addiction on the user.

Depressants – alcohol

<table>
<thead>
<tr>
<th>Behaviours or patterns changing from the norm over time</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Frequent hangovers.</td>
</tr>
<tr>
<td>• Increased absenteeism.</td>
</tr>
<tr>
<td>• Decline in work performance.</td>
</tr>
<tr>
<td>• Increase in accidents.</td>
</tr>
<tr>
<td>• Incidents of unintentional unsafe sex.</td>
</tr>
<tr>
<td>• Increased aggression, irritability.</td>
</tr>
<tr>
<td>• Reduced personal hygiene or attention to appearance.</td>
</tr>
<tr>
<td>• Deterioration in relationships.</td>
</tr>
<tr>
<td>• Social withdrawal, reduced scope of activities.</td>
</tr>
<tr>
<td>• Alcohol-related offences.</td>
</tr>
<tr>
<td>• Financial problems.</td>
</tr>
</tbody>
</table>

There are a number of health-related problems as a result of prolonged excessive use of alcohol, including: depression, anxiety, altered sleep patterns, hypertension, gastritis, impotence and memory loss. Severe dependence can result in liver disease (cirrhosis), pancreatitis, oesophageal varices, and peripheral neuritis.

LEARNING ACTIVITY – Scenario about John

John is a 46 year old European man who is separated from his wife of 19 years after she left him once their son moved out of the family home. He is a foreman in a factory where heavy machinery is used and has been in the same job for 15 years. John is a keen pool and billiards player and typically drives to the club after work for “a few drinks”. He drinks 2 or 3 jugs of beer nightly, but on a Saturday, drinks about 4 or 5 jugs while playing pool or bowls, when he gets in the tournaments. On Sundays, he usually has about 3 or 4 cans in front of the TV but this may be more if people come over.

John says he is not really a spirit drinker, but he has a “whisky or two” as chasers after a good night at pool or billiards, or at parties. With Mary leaving him, John feels pretty down and spends a lot more time at the club, and has his evening meal there as well. He is usually there now until closing, and admits his drinking has probably gone up a couple of jugs per day. He doesn’t think he has a problem and puts it down to “feeling depressed”.

Careerforce – Issue 2.0 – March 2017
What effects might John’s drinking be having on him?

### Inhalants

**Signs or behaviours which may indicate a problem with solvent use:**

- Discolouration around the nose or mouth from products used.
- Smell of solvents in breath, on skin, in hair or clothing.
- Presence of solvent containers/bags with smell or residue, spray cans etc.
- Increased salivation, runny nose, cough and sneezing (not due to cold or hay fever).
- Dry skin/sores around mouth/nose.
- Decreased reflexes, oscillating eye movement.
- Mood swings, disinhibition, aggression, together with above signs.
- School absenteeism, decline in academic performance, with above signs.
Mrs Brown has brought her 15 year old son Troy into the doctor’s surgery asking if he can have a physical examination because she is really worried about him. She says that Troy has been in a bit of trouble lately and was expelled from school for fighting, missing classes, forging a note to say he was sick, and putting graffiti on the school walls. She says that he appears very pale and isn’t washing or looking after himself as well as he used to. She also says his clothing sometimes stinks of chemicals and sometimes has paint stains that are hard to remove. He also seems to constantly have a runny nose and some sort of nasty cold sore around his nose and mouth.

Troy has been sitting quietly and looking sullen and looks quite unkempt. On examination, he smells of solvents and has a circular rash around his mouth. He has a runny nose and a light cough. When asked how he is feeling, Troy says he is okay and there’s nothing wrong. When asked what the glue-like smell is, Troy says he and his mates have been doing a bit of tagging, but only in places no-one cares about, not around the school. He also says that one of his mates is into models and they have put together a couple of plastic airplanes. When asked how long he has had the sores around his mouth, Troy said he was a bit worried that they had got worse and had been there over a week. When told that glue can cause a rash in some people, Troy admitted he had tried sniffing a bit of glue in a bag that his mate had told him to try, but he didn’t do it much. He asked how long the rash would take to go away and if he could have something to get rid of it.

What effects might Troy’s inhalant use be having on him?
Stimulants – nicotine

<table>
<thead>
<tr>
<th>Signs or behaviours which may indicate the presence of tobacco use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chain smoking – early onset of dependence.</td>
</tr>
<tr>
<td>• Financial distress.</td>
</tr>
<tr>
<td>• Clothes and breath smell of smoke.</td>
</tr>
<tr>
<td>• Experience limited jobs and social environments due to the Smoke-free Act.</td>
</tr>
<tr>
<td>• Premature ageing and more wrinkles.</td>
</tr>
<tr>
<td>• Yellowing of the skin and smoke stains on fingers and teeth.</td>
</tr>
<tr>
<td>• Reduced fitness.</td>
</tr>
<tr>
<td>• Poor sleep and appetite.</td>
</tr>
<tr>
<td>• Development of life threatening diseases.</td>
</tr>
</tbody>
</table>

Without the nicotine there can develop a psychological and physical craving for the nicotine, depressed mood, irritability, anxiety, restlessness, concentration difficulties and increased appetite. Withdrawal commences after a few hours of last smoking, peaks after a few days, and gradually subsides over weeks. Relapse is common.

**LEARNING ACTIVITY – Scenario about Thomas**

Thomas is a 50 year old man of Pacific descent. He is a building contractor and recently saw his GP for his annual health check (as required by his current employer). This health check highlighted some areas of concern. His blood pressure is high, mainly caused by smoking. Also, Thomas has taken on coaching his son’s rugby team this season but finds he gets breathless running around the pitch.

Thomas’s son comments about finding his dad up in the middle of the night smoking a cigarette which he never remembers him doing when he was younger. His dad just says he’s having trouble sleeping.

What effects might Thomas’s smoking be having on him? How might it affect his employment?
Amphetamines

<table>
<thead>
<tr>
<th>Signs or behaviours which may indicate use of psychostimulants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Overly dilated pupils.</td>
</tr>
<tr>
<td>• Injection sites (intravenous users).</td>
</tr>
<tr>
<td>• Runny or bleeding nose, nose ulcers (snorters).</td>
</tr>
<tr>
<td>• Signs of exhaustion/wakefulness.</td>
</tr>
<tr>
<td>• Loss of sense of smell (snorting cocaine).</td>
</tr>
<tr>
<td>• Mood swings, increased paranoia,</td>
</tr>
<tr>
<td>uncharacteristic violent behaviour.</td>
</tr>
<tr>
<td>• &quot;Withdrawal symptoms&quot; (quicker with cocaine) – restless,</td>
</tr>
<tr>
<td>irritable, anxious, depressed and craving.</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

LEARNING ACTIVITY – Scenario about Robert

Robert is a 26 year old European man who has contacted you for some “confidential” advice, as he is worried about the state of his health. When he talks, you notice that he is pretty hyped up, talks fast, seems to keep changing the subject and fidgets a lot. He looks really tired and says he feels “stuffed” and hasn’t slept for two days. He wants to know if taking meth is as bad as people say it is and if it is addictive, because even though he wants to stop, he hasn’t got around to it yet, and he doesn’t have much money left either. He says when he started it felt great, but now his moods are “all over the place” and he thinks he looks terrible. Robert says he left his job because he “couldn’t keep it together” and he broke up with his girlfriend too. He has started worrying about where he is headed, and wants to straighten himself out.

What effects might Robert’s meth use be having on him?
Cannabis

Behaviours or patterns changing from the norm over time

- Incongruency in mood or reactions to situations (eg inappropriate laughter).
- Changes in ability to focus, follow instructions, concentrate on tasks.
- Decrease in work performance.
- Absenteeism.
- Lack of energy or interest in things which used to be important.
- Social withdrawal and loss of interest in relationships.
- Decline in attention to personal hygiene and appearance and erratic lifestyle.
- Increase in suspicion, mistrust, and paranoia.
- May lead to drug-induced psychosis especially with early onset.
- Restlessness and irritability.
- Association with regular users.
- Cannabis-related offences.

LEARNING ACTIVITY – Scenario about Rangi

Rangi is a 20 year old Māori with a European mother and a Māori father. He has an English girlfriend that his father doesn't approve of and Rangi doesn't get along with his father because of fights when his father was drinking in the past. Rangi says that he has smoked a tinny a week since he was 15, when one of his mates was in a tinny house. Over the last year or so, Rangi has increased his smoking to at least two joints daily and sometimes four or five on the weekend.

Rangi says that he doesn’t think his girlfriend or parents know he smokes. He thinks that cannabis helps him mellow out and then he can handle his angry thoughts toward his father, which have been increasing lately. Rangi thinks the cannabis might be making him feel paranoid and he also feels less energetic and motivated than he used to, but he doesn’t drink like his father did or waste his money or time on any other bad habits. He says that cannabis is harmless and “everyone he knows smokes anyway”.

What effects might Rangi’s cannabis use be having on him?
Opioids

<table>
<thead>
<tr>
<th>Signs or behaviours which may indicate opioid use disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Signs of intoxication.</td>
</tr>
<tr>
<td>• Needle tracks on arms/legs.</td>
</tr>
<tr>
<td>• High risk of infectious diseases.</td>
</tr>
<tr>
<td>• Changes in lifestyle, social structure, and association with drug users.</td>
</tr>
<tr>
<td>• Social withdrawal and isolation.</td>
</tr>
<tr>
<td>• Deterioration in hygiene, personal appearance over time.</td>
</tr>
<tr>
<td>• Withdrawal symptoms, “hanging out” for drugs.</td>
</tr>
<tr>
<td>• Presence of syringes/equipment for drug use.</td>
</tr>
<tr>
<td>• Deterioration in work performance.</td>
</tr>
<tr>
<td>• Absenteeism/absences which may indicate drug seeking.</td>
</tr>
<tr>
<td>• Increased sickness/health problems.</td>
</tr>
<tr>
<td>• Breakdown in relationships.</td>
</tr>
<tr>
<td>• Increased financial problems.</td>
</tr>
<tr>
<td>• Drug and other offences to support drug habit.</td>
</tr>
</tbody>
</table>

LEARNING ACTIVITY – Scenario about Marnie

Marnie is a part Chinese 25 year old solo mother. Recently a neighbour complained that she wasn’t caring for her two year old daughter properly. Marnie claimed she was a good mother but was struggling on the benefit, so she sometimes had to leave her daughter with neighbours so she could work. She became tearful, and admitted that her boyfriend had been supplying her with morphine, which she had been injecting two or three times a week. She said her boyfriend wanted her to work in a massage parlour but she had been resisting this even though she could do with the easy money. She was sure that she didn’t have a “habit” yet, but was worried that her boyfriend kept giving morphine to her and she was starting to crave it, especially when under stress.

What effects might Marnie’s morphine use be having on her?
Hallucinogens

<table>
<thead>
<tr>
<th>Signs or behaviours indicating use of hallucinogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Apathy, social withdrawal.</td>
</tr>
<tr>
<td>• Flashbacks (re-occurrences of experiences in “bad trips”).</td>
</tr>
<tr>
<td>• Risk of precipitating psychosis.</td>
</tr>
<tr>
<td>• Risk of spontaneous abortion and birth abnormalities.</td>
</tr>
</tbody>
</table>

LEARNING ACTIVITY – Scenario about Joseph

Joseph is a 21 year old university student who has come in to the student counselling service for the first time. He takes a while to settle and wants to know the counsellor’s qualifications and how much experience he’s had before he states his problem. Joseph says that he is worried about his mental state and says he wonders sometimes if he’s going mad. He says that his marks have dropped lately and he thinks that lecturers have been watching him to see if he is smart enough to be here. He says that he has become more anxious lately and has had some “really weird experiences” in his thinking and some pretty strange dreams, and he wondered if it might be due to some stuff he tried.

Joseph said that he doesn’t drink much or get into drugs usually, but he has a friend who found a supply of mushrooms. His friend said that these mushrooms would give them a “really good buzz” and expand his thinking, and he would understand a lot more about life and the universe etc. Joseph said he was willing to try something different but wasn’t prepared for the effects. He said he had a real “bad trip” and freaked out over some of the things he saw and felt, and hadn’t been right since. He felt he really needed to talk to someone and make sure he wasn’t going crazy. He was all right most of the time, but now and again he had the same awful feelings he had when he was on his “bad trip” and he just wanted it to be over. He said that he would feel better if someone could explain what was going on and that he wasn’t becoming mentally ill.

What effects might Joseph’s mushroom use be having on him?
Ecstasy

<table>
<thead>
<tr>
<th>Signs or behaviours indicating use of ecstasy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 60% report withdrawals: fatigue, loss of appetite, depression, anxiety, lack of concentration.</td>
</tr>
<tr>
<td>• Causes muscle tension, teeth clenching, nausea, blurred vision, chills, sweats and faintness.</td>
</tr>
<tr>
<td>• Drug effects mask the body’s sense of exhaustion and thirst, so users can be dehydrated and overheated.</td>
</tr>
<tr>
<td>• Same risk as amphetamines – increased heart rate, blood pressure and body temperature. Can cause liver, kidney and heart failure. Can be fatal.</td>
</tr>
</tbody>
</table>

LEARNING ACTIVITY – Scenario about Josie

Josie is an 18 year old European woman who has been taken to hospital after she collapsed at a night club on Saturday night. Josie has regained consciousness, but even though she appears exhausted and dehydrated, she wants to leave and go back to the club. Josie’s boyfriend and her sister don’t want her to leave until they are sure she is all right. They said that Josie had been acting strangely and really hyped up and they suspect someone has “given her something”. Josie does appear pretty elevated in mood and is very talkative even though she still appears washed out.

Josie says she takes “E” when she goes out because she has more fun and can go all night. She has taken several in the last couple of days and says she hasn’t had any sleep since Thursday night. Josie says she loves dancing and parties and thinks ecstasy is harmless and is not a real drug. She says all her friends do the same and have a great time. Josie agreed to stay in hospital overnight when she heard that she was quite sick, but says there is another party going on Sunday night that she really wants to go to, so she is hoping that she will be discharged from hospital early in the morning.

What effects might Josie’s E use be having on her?
Effects on the natural supports of users

Biopsychosocial impact

Natural supports refers to any assistance, relationships or interactions provided to service users by family/whānau, friends, peers, co-workers or community volunteers.

Natural supports of those affected by their use of alcohol and other drugs are often impacted in a biopsychosocial way. That is, they are often impacted physically, mentally and socially. The degree of impact is influenced by how close they are to the person using, not by what type of alcohol or drug use is involved.

From a physical point of view, family may feel unsafe from the violence that the addiction might bring on. The disinhibition brought on by substance abuse could have very unsafe and unpredictable outcomes, especially in the case of drugs that increase violent behaviours. As many drugs are associated with illegal and criminal actions, this too could create situations of unsafe physical circumstances.

From a psychological perspective, the damage could have more long term effects. Traumatic childhoods are often a predictor of addiction, which in turn continues to impact on current relationships. Some families are dealing with current addiction issues as well as the impact of addiction from family of origin issues. This cycle will have great impact on trust in intimate relationships and the development of destructive parenting styles. Families where addiction may have been a historical feature in their family of origin may struggle to have a model of normalcy for managing their current family circumstances.

Even without an historical feature, the strain on natural supports of those affected by substances is emotionally arduous. Many significant others will experience similar mental health conditions to the user, such as depression, anxiety and suicidal ideation brought on by living the rollercoaster of addiction through the user’s experience. In some cases, significant others have succumbed to addiction as a result of the mental anguish.

Psychological abuse, isolation from shame and stigma, and wearing the weight of all family responsibility due to the user’s disconnection with obligations often weigh emotionally on the natural supports. Natural supports are often left taking care of the user as well as the rest of the family. This experience for many leads to marital and family breakups.
Socially, addiction will bring on financial distress due to loss of employment and money going towards drug use. Potential legal problems and a distancing from extended family and friends will also occur. Often co-workers will have to compensate for work getting done, only to resent having to do this. The user may be drawn into association with other drug users, rather than family and friends not associated with drugs.

Addictions also impact greatly on the cultural and spiritual wellbeing of an individual, the substance user and natural supports. Often cultural identity and spiritual beliefs are eroded and abandoned due to the continual impact of substance abuse. Some cultures are at risk populations to substance abuse. Increasingly, treatment services place high priority on cultural and spiritual interventions.

**Effect on primary natural supports**

Children are often the most impacted by a user. They will be exposed to second-hand smoke dangers and witness the intoxicated states of their parents. They will blame themselves for why a parent does not follow through with promises made. They will reverse roles and often parent the user as a way to survive and feel closer to the user. They are the most exposed to social welfare services as a result of parents losing custody of their children due to addiction.

Partners and parents of adult children will also blame themselves for the addiction. They will often become consumed with trying to gain control or put all their energy into getting the user help at the expense of addressing their own needs. They often put their hopes into the individual receiving treatment and making the necessary changes to return their lifestyle back to “normal”. However, they often need encouragement to focus on their own needs and obtain personal support, despite the motivation or otherwise of the user to make changes in their substance use or behaviour.

Natural supports of substance users are often very resilient. Families will make allowances and have strengths to survive the adversity. Sometimes the allowances can be seen as maladaptive ways of coping with high stressors. To cope, family may minimise or deny concern or turn away and ignore the substance use, which does not work towards addressing the problem. However, when more care is put into supporting the family to cope in less maladaptive ways, better outcomes occur for the addicted service user. It is often said that succeeding in the recovery process for substance users and natural supports is one of the greatest challenges and achievements in life’s experiences.
Rewind to pages 41–49.

**Alcohol:** Re-read the scenario about John, on page 41.

<table>
<thead>
<tr>
<th>What effects might John’s drinking have on his wife of 19 years and their son?</th>
</tr>
</thead>
</table>

**Inhalants:** Re-read the scenario about Troy, on page 43.

<table>
<thead>
<tr>
<th>What effects might Troy’s inhalant use have on his mother and schoolmates?</th>
</tr>
</thead>
</table>
**Nicotine:** Re-read the scenario about Thomas, on page 44.

<table>
<thead>
<tr>
<th>What effects might Thomas’s smoking have on his son?</th>
</tr>
</thead>
</table>

**Amphetamines:** Re-read the scenario about Robert, on page 45.

<table>
<thead>
<tr>
<th>What effects might Robert’s meth use have on his ex-girlfriend and workmates?</th>
</tr>
</thead>
</table>
**Cannabis:** Re-read the scenario about Rangi, on page 46.

<table>
<thead>
<tr>
<th>What effects might Rangi’s cannabis use have on his girlfriend and parents?</th>
</tr>
</thead>
</table>

**Opioid:** Re-read the scenario about Marnie, on page 47.

<table>
<thead>
<tr>
<th>What effects might Marnie’s morphine use have on her daughter, even though she’s only two years old, and on her neighbours?</th>
</tr>
</thead>
</table>
**Hallucinogen:** Re-read the scenario about Joseph, on page 48.

<table>
<thead>
<tr>
<th>What effects might Joseph’s mushroom use have on his relationships with his student friends and lecturers?</th>
</tr>
</thead>
</table>

**Ecstasy:** Re-read the scenario about Josie, on page 49.

<table>
<thead>
<tr>
<th>What effects might Josie’s E use have on her boyfriend and sister?</th>
</tr>
</thead>
</table>
The continuum of substance use problems

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt really embarrassed; couldn’t remember what she did last night or how she got home.</td>
<td>5*</td>
<td>More serious if it has happened several times.</td>
</tr>
<tr>
<td>He wakes up after a heavy night, has shaking hands, and reaches for another drink.</td>
<td>7</td>
<td>Withdrawal symptoms indicate physical dependence.</td>
</tr>
<tr>
<td>Five months pregnant, she pours herself a glass of wine, lights another cigarette.</td>
<td>6</td>
<td>Disregard of risk to unborn child may indicate more serious problem or lack of education.</td>
</tr>
<tr>
<td>On the job, he finds himself continuously looking at the clock for closing time as he is dying for a drink.</td>
<td>6**</td>
<td>Increased time of preoccupation with alcohol may indicate progression of problems.</td>
</tr>
<tr>
<td>They called the police again after hearing the neighbour come home drunk and start beating up his wife.</td>
<td>6*</td>
<td>May have primary anger/violence problems or changes behaviour after intoxication.</td>
</tr>
<tr>
<td>He’s been using escalating amounts of methamphetamines over the last six months to keep his competitive edge at work.</td>
<td>4</td>
<td>Tolerance may be increasing – no mention of other problems as yet.</td>
</tr>
<tr>
<td>He’s on his second warning from work for too many days off, always on Mondays.</td>
<td>5*</td>
<td>Could be other issues besides drugs or alcohol.</td>
</tr>
<tr>
<td>He freaked out after an acid flashback.</td>
<td>3–4**</td>
<td>May have been a one-off try.</td>
</tr>
<tr>
<td>She’s over the legal limit at a motorway police check after a night out with friends.</td>
<td>3*</td>
<td>This can happen also to inexperienced drinkers.</td>
</tr>
<tr>
<td>Gets a pat on the back from his mates outside the grocery store for getting away with a 12 pack of beer without ID.</td>
<td>3*</td>
<td>May be young regular drinker or may be young person’s risk-taking behaviour.</td>
</tr>
<tr>
<td>He promised his girlfriend that this time, he would only have a few at the local tonight.</td>
<td>4</td>
<td>Getting drunk may be regular occurrence, with resulting obnoxious behaviour.</td>
</tr>
<tr>
<td>She pours vodka taken from her parents’ home bar into her hip flask before she goes out to a party.</td>
<td>3*</td>
<td>Could be risk-taking behaviour or could be “priming” for confidence.</td>
</tr>
<tr>
<td>He is begrudgingly at the bach for the family holiday. His parents notice he’s irritable and not sleeping well.</td>
<td>4*</td>
<td>Could be withdrawing from an addictive behaviour or have financial or other concerns.</td>
</tr>
<tr>
<td>After the kids are put to bed, he goes outside to smoke the joint he just rolled.</td>
<td>4*</td>
<td>May be regular behaviour or occasional/recreational.</td>
</tr>
<tr>
<td>Looking gaunt and covering up the track-marks on her arms, heavily made-up, she stands on the street waiting for a trick.</td>
<td>7–8</td>
<td>IV user, appears physically debilitated, caught up in sex industry to finance drug use.</td>
</tr>
<tr>
<td>Instead of stealing one tube of glue, he thought he’d try for three this time.</td>
<td>3**</td>
<td>Escalating solvent use, taking more risks.</td>
</tr>
<tr>
<td>The parties are always at his house because he never runs out of booze.</td>
<td>6*</td>
<td>Either exceptional host or more likely, regularly prioritises alcohol.</td>
</tr>
<tr>
<td>As soon as he walks in the door, his mum confronts him about the two joints in his room.</td>
<td>3*</td>
<td>May use regularly; may have recently obtained to share.</td>
</tr>
<tr>
<td>Being a recreational user of drugs like ecstasy, LSD and cannabis since his teens, he tries P for the first time at a party.</td>
<td>4</td>
<td>Long time user and moving to try more dangerous drugs – risk of more severe consequences.</td>
</tr>
<tr>
<td>Indicators of alcohol and other drug (AOD) problems</td>
<td>Drug name and type</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Disinhibition, uncoordinated movements, drowsiness, increased absenteeism.</td>
<td>Alcohol – a CNS depressant.</td>
<td></td>
</tr>
<tr>
<td>Lost interest in things which were important, difficulty with concentration, paranoia and suspicion, mood incongruent to situation (eg inappropriate laughter).</td>
<td>Cannabis – a CNS depressant and hallucinogenic.</td>
<td></td>
</tr>
<tr>
<td>Intoxication (disinhibited, drowsy); absences, absenteeism, erratic lifestyle; marks/tracks on arms/legs (or purposely covered); frequent periods of sickness or health issues.</td>
<td>Morpheine is an opioid – a CNS depressant.</td>
<td></td>
</tr>
<tr>
<td>Tired and exhausted, but wide awake; alert and talkative; raves/party lifestyle; absenteeism, especially Mondays after weekend partying.</td>
<td>Ecstasy – a stimulant and hallucogen.</td>
<td></td>
</tr>
<tr>
<td>Confusion, disorientation, slurred speech, incoordination, discolouration around mouth.</td>
<td>Glue is a solvent – a CNS depressant.</td>
<td></td>
</tr>
<tr>
<td>Dilated pupils, decreased concentration, out of touch with self and/or environment, flashbacks (re-experiencing anxiety and/or panic)</td>
<td>Mushrooms and cactus are hallucinogens.</td>
<td></td>
</tr>
<tr>
<td>Appears “high” or euphoric, overconfident; rapid, pressured or slurred speech; paranoid, aggressive, violent or unpredictable behaviour.</td>
<td>Drug “P” – is a stimulant.</td>
<td></td>
</tr>
<tr>
<td>Frequent brief absences from other activities, respiratory problems, distinctive smell, irritability or agitation when unable to leave situations for long period.</td>
<td>Nicotine – is a stimulant.</td>
<td></td>
</tr>
<tr>
<td>Impaired judgement, risk-taking, slurred speech, inability to recall previous night’s events, deterioration in relationships.</td>
<td>Alcohol – a CNS depressant.</td>
<td></td>
</tr>
<tr>
<td>Social withdrawal; loss of energy, apathy, relaxed, “laid-back”, drowsy; increased appetite (especially fast foods) – “the munchies”.</td>
<td>Cannabis – a CNS depressant and hallucinogenic.</td>
<td></td>
</tr>
<tr>
<td>Social withdrawal or isolation; increased offences, legal problems (eg pharmacy robbery); decreased work performance, frequent unemployment; financial problems; deterioration in appearance and/or assets.</td>
<td>Homebake is an opioid – a CNS depressant.</td>
<td></td>
</tr>
<tr>
<td>Increased urination; irritable, rigid, intolerant; reduced memory, concentration; stimulated, then drowsy or lethargic.</td>
<td>Alcohol – is a CNS depressant.</td>
<td></td>
</tr>
</tbody>
</table>
Common non-substance addictions

There is a growing interest in non-substance addictions which some refer to as behavioural addictions, even though controversy remains as to whether or not behavioural addictions exist. With our growing knowledge in neuroscience, we are seeing that behaviours, much like substances, can influence brain chemistry and this is significant to the field of addictions (Chase and Clark, 2010).

There is growing evidence that neurotransmitters in the brain, such as dopamine and norepinephrine, are directly linked to addictive responses to substances and behaviour. Biologically, it helps to explain increased tolerances and lowered inhibitions to risk-taking that is often progressively associated with substance and behavioural addictions (Comings et al, Tomkins and Seller, 2001). There is also some suggestion that genetically predisposed low neurotransmitter production may be the cause for seeking out risk-taking behaviours that lead to addiction.

Behaviours that are reward-seeking in nature and that create pleasure and positively enhance life experiences can develop into preoccupations, especially if partly to relieve stress. We then see an increased continuation in the behaviour despite negative consequences. Adaption then occurs with tolerance and withdrawal features beginning to emerge, and unsuccessful attempts to control the behaviour (Albrecht et al, 2007). Griffiths (2005), describes these features as being part of a components model of addiction within a biopsychosocial framework. The components of this model are: salience, mood modification, tolerance, withdrawal symptoms, conflict and relapse. These components represent non-substance addictions as well as substance addictions.

There are a growing number of behaviours that are considered non-substance addictions: problem gambling, food, sex, shopping, internet, work, risk-taking. Many of these are now in the DSM-5.

In the discussions which follow we have included references to recent published work in these areas, so you can explore these growing addictive behaviours in more depth, should you wish.

References
Gambling

Gambling is a common pastime with approximately 65% of New Zealanders participating in some form of gambling, spending approximately $2 billion a year. The most common forms of gambling are Lotto, Instant Kiwi, raffles, and pokie machines. New forms of gambling have developed over the last decade or so, including, casinos, internet gambling, text gambling, and gambling over the phone (0900 numbers and TAB Phonebet). Gambling machines became legal in NZ in 1988 and have now become the largest mode of gambling based on our gambling spend.

DSM-5 newly recognises gambling disorder as similar to substance-related disorders.

For a small proportion of people, gambling can cause problems.

- Approximately 4% of New Zealanders may be experiencing moderate or severe gambling problems. Approximately 10% of those with gambling problems will seek help from problem gambling specialists. However, many more may disclose their problems to others if they are asked appropriately (eg invited to complete a problem gambling screen; treated empathetically).
- As with drugs, different forms of gambling have different potential to cause problems. For example, few people present for help for problems with Lotto, housie or raffles. Many, however, present with gambling machine problems and these make up the majority of problems disclosed to problem gambling therapists.
- Women are just as likely as men to develop gambling problems.
- Māori and Asian cultures are 3 times more likely and Pacific cultures 6 times more likely than Europeans to develop problems, due to lower socioeconomic issues.
- The Gambling Act (2003) and subsequent Regulations focus on harm minimisation and gaming industry responsibilities. There are procedures by which people can exclude themselves from places such as casinos.

<table>
<thead>
<tr>
<th>Gambling Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can move up and down</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>65%+ adults gamble in NZ</th>
<th>Problem Gamblers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most people</td>
<td>A minority</td>
</tr>
<tr>
<td>97%–95% all adults who gamble</td>
<td>2%–3% all adults</td>
</tr>
</tbody>
</table>

- No problems
- Entertainment
- Moderate problems
- Chases losses
- Guilt
- Arguments
- Concealment
- Some depression
- High expenditures
- Severe problems
- Depression
- Serious suicide thoughts
- Relationship breakup
- Debt & poverty
- Crime
Before you go any further in this workbook, think about...

Use your instincts to determine the following scenarios. Later in your learning come back to these scenarios to see if your thoughts have changed. Fill in a rating number and any comments for each behaviour based on the below continuum.

The problem-severity continuum – gambling

<table>
<thead>
<tr>
<th>No use</th>
<th>Few problems</th>
<th>At-risk</th>
<th>Moderate problems</th>
<th>Serious problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Relative severity is a guide only. Actual severity depends on assessment.

The first answer is done for you, in red. Suggested answers are on page 78.

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>At casino, pokies jackpot winner shouts food and drinks to friends.</td>
<td>1</td>
<td>Normal social behaviour.</td>
</tr>
<tr>
<td>Has great “system” with horses, says he is going to make lots of money.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has money in lots of different envelopes in her handbag and uses one for the pokies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t afford to get car out of casino car park.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argues with cashiers at the track for being slow, missing bets and making mistakes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argues with family/whānau members about placing more bets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well dressed, shows no emotion when places large bets or picks up large dividend.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spends more and more time at the TAB and is becoming more scruffy/unshaven.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argues with another customer using their favourite machine after it wins.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>He looks stressed while placing his last bets and has trouble getting money from eftpos.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks for credit at the TAB for the last race, promises he’ll pay it all back after winning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leaves child in car while gambling, for several hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plays two machines at the same time.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Internet addiction

The internet is the most significant change in entertainment and information technology since the television. During this shift there have been offline advancements with computers, gaming and telephone technology, but now these technologies have merged with online capability. In particular, youth are showing as a high risk population drawn to digital and online gaming, online gambling, cellular phones, and social media platforms. However, the adult population is equally at risk as the internet holds great relevance to the present and future in work, study and social experience.

While considered for the DSM-5 as a compulsive-impulsive spectrum disorder for online and offline computer usage it was considered that further clarification of criteria was needed. Hechanova and Czinč in their Internet Addiction in Asia: Reality or Myth? (2008) speak of three categories for consideration when attempting to define internet addiction:

1. Length of time spent online.
2. Type of online activity pursued.
3. Functional impairment to daily life.

Length of time spent online remains a difficult predictor as the internet use needs to be put into context with current life experiences. For instance, people often use the internet as part of their job or for long-distance relationships.

For type of online activity pursued, Young (1996) defined five subtypes of internet addiction (as cited in Hechanova and Czinč, 2008, p. 7).

1. Cybersexual addiction: compulsive use of adult websites for cybersex and cyberporn.
2. Cyber-relationship addiction: over-involvement in online relationships.
3. Net compulsions: obsessive online gambling, shopping, or day-trading.
4. Information overload: compulsive web surfing or database searches.


These subtypes are similar in content, but grouped slightly differently.

It is suggested that interactive functions on the internet will increase the chance of internet addiction.
Sex addiction
Sex addiction refers to an obsession with or compulsive need for sex. As a behavioural addiction, sex becomes a preoccupation that consumes a person’s thoughts and activities. Planning, anticipating and acting out the behaviour have significant impacts on mood modification. Sex addicts experience real highs, emotional escape and relief from stress when engaging in the behaviour.

Due to the repetitive nature and cyclical pattern of addictions, tolerances will build for sex addicts. They will increasingly engage in a number of sexual encounters and develop lower sexual inhibitions to achieve mood expectations and satisfaction, often placing themselves and others in increasingly riskier situations. This will create conflict with other significant aspects of their lives, and emotional numbing as a coping mechanism will help to override remorse and guilt so that the behaviour can continue. Often substances will be used to assist the numbing effect as a way of self-medicating. This will also assist with managing withdrawal symptoms and feelings of losing control, especially if attempts to change have failed.

Food addiction
Recognition of research criteria for binge-eating disorders offers some recognition of food addiction. Some associated features of this disorder are that it might be triggered by dysphoric (unhappy) moods and it can impact on relationships, work and the ability to feel good about oneself. The DSM-5 has a section on feeding and eating disorders criteria for anorexia nervosa, bulimia nervosa and binge eating.

Food addiction meets all of the diagnostic criteria of substance dependence. This was affirmed by Volkow and O’Brien (2007) who described food addiction as a brain disorder recognising the mental health component of obesity. They highlight that obesity needs to be recognised for its genetic, developmental and environmental factors.

From a physiological point of view, Ifland et al (2009) suggest that food addiction’s association to substance use disorder should be focused primarily on the effect of refined foods, such as sugar, salt, fat and refined carbohydrates. These foods appeal to the reward-seeking pathways that can override the need for food for energy and can lead to malnutrition.

With the rise in rates of obesity, compulsive overeating or food addiction is a real concern. For overeaters, food becomes one of the most important activities in their lives. Food has the ability to create pleasure as well as to escape stress and negative emotion.
Continual overeating will raise tolerances to need more and more food to get the desired effect, which then gives way to withdrawal symptoms in the form of excess moodiness, food cravings and irritability. Overeaters will continue to engage in this addictive cycle no matter what the consequences. Even with heightened awareness to the consequences, overeaters will be challenged by relapse after attempts to change.

References

Work addiction

Work addiction, often referred to as workaholism, is a “respectable addiction”. It is not clearly defined nor recognised diagnostically, but it has obsessive-compulsive attributes. Work addicts work excessively out of feeling compelled to do so or out of enjoyment, as some work addicts get great pleasure from their excessive behaviour. For others, they feel compelled to be at work for long hours and are very stressed if not at work, often afraid they will not be able to keep up if away from work too long.

Work addicts are not necessarily hard workers, as they may be masking anxiety and low self-esteem. They can be ineffective employees, getting caught up into procrastinating behaviours and struggling to meet work deadlines even though spending a lot of time at work (Robinson and Post, 1995). They can be busy all the time even when it is not necessary, and are known to take on too much to be productive.

In many cultures and through influences of family of origin, it is condoned to spend a lot of time at work. Men are seen as affected by this more than women (Harper and Snir, 2003). In today’s society, more people work longer hours from home offices and more productivity is expected in jobs, keeping people at work longer. Work addicts will not have time for other interests and put little time into relationships at work and at home. Workaholics will rarely delegate or trust co-workers to do a job for them. When at home, they will be preoccupied with work issues and lack intimacy.

Health issues will surface for work addicts. They are at risk of sleep deprivation, headaches, high blood pressure, stomach ulcers and strokes. They will be affected by weight gain or loss, and poorly attend to exercise and nutrition.

References
**Shopping addiction**

Shopping addiction is also known as compulsive buying and compulsive spending. It is an overriding need to shop and spend money. It has features that could align with obsessive-compulsive and impulse control disorders. Within a behavioural addiction framework, compulsive spending manifests a preoccupation with seeking out merchandise and spending money on it. These actions are highly influenced by anticipated mood responses of elation and stress relief.

Addicts will look for increasing opportunities and justifications to shop and spend, which will increase higher risk behaviour. Addicts will increasingly buy on credit as debt mounts and may even resort to theft to feed their addiction. They will often shop alone and hide their purchases to avoid confrontation and guilt.

There can be several reasons for compulsive spending. Prevalence studies have shown that up to 6% of the population in the USA could have this addiction. Social conditions are influential in encouraging consumerism, and increasingly purchases can be made without leaving home. Like other addictions, compulsive spending may be a maladaptive way for dealing with unresolved emotions. Compulsive spenders will engage in this behaviour to combat loneliness, boredom, to feel special and manage emotional deprivation. For others, compulsive spending is driven by the need to achieve perfectionist results in self-identity. Women show stronger tendencies than men towards this rationalisation.

**Risk-taking**

Risk-taking is often described by common terms such as “adrenaline junkie”. In this context, risk-taking could be viewed as an addiction as people are perceived to take risks to experience an adrenaline rush, which is usually brought on by a fight or flight response when someone experiences danger or excitement. Adrenaline, also known as epinephrine, is a neurotransmitter in the brain, like dopamine and norepinephrine, and can be influenced by substance and behaviour addictions. It may be said that risk-takers look for opportunities, which may be seen as healthy or unhealthy, to experience an adrenaline rush.

In contrast to a common understanding of risk-taking as an addiction, theorists believe that risk-taking is more of a trait, distinguishing features of a person’s character brought on by biological and environmental influences. Also known as sensation-seekers, risk-takers may be driven by impulsiveness to respond to their environment in a risky way, which can often lead to crime and addictions such as drugs, gambling and sex.
Effects on addiction service users

Gambling disorder

Signs, symptoms and risky behaviours

DSM-5 includes gambling disorder as a behavioural addiction as new research shows this is similar to substance-related disorders in clinical expression, brain origin, comorbidity, physiology and treatment.

Observing people and concluding whether or not they have a gambling problem, is a difficult task. In the past it has been called "the hidden disorder", and many affected will try to cover up their gambling because of guilt and shame.

Many newer forms of electronic gambling, such as gambling machines, appear to dominate the types of gambling problems that clients who seek help disclose to treatment providers. In addition, problems appear to develop quickly, confusing both those gambling, and others, as to how they got to that stage so quickly.

Unlike other addictive behaviours, signs of problem gambling are not as clear. Many signs of gambling may also result from something other than a gambling problem. Signs are clearer when they are collected together and changes in behaviour are noted over time.

Examples of gambling signs are:

- Unpaid debts and ongoing financial problems that are explained as due to unfortunate events, eg lost wallets, unexpected car repairs.
- Unexplained absences when their presence was expected, eg late return to work after lunch break.
- Deterioration in self-care, eg clothing and hygiene, possibly due to depression arising from gambling problems.
- Requests for loans that are subsequently not repaid.
- Downplaying the amount of time and money that they say they spend gambling.

The DSM-IV called it pathological gambling. This often involves repetitive behaviours. People with this problem have a hard time resisting or controlling the impulse to gamble, which can lead to severe personal or social consequences. In these people occasional gambling leads to a gambling habit. Stressful situations can worsen gambling problems.

Gambling disorder is associated with many issues, such as alcohol misuse, tobacco use and criminal offending to support a gambling habit. Gamblers may be at risk of depression, anxiety and suicidal thoughts and attempts. Family breakdown is high.
Criteria for gambling disorder

A Persistent and recurrent problematic gambling behaviour leading to clinically significant impairment or distress as indicated by an individual exhibiting four (or more) of the following in a 12 month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.
4. Is often preoccupied with gambling (e.g. preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble).
5. Often gambles when feeling depressed (e.g. helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even (“chasing” one’s losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve a desperate financial situation caused by gambling.

B The gambling behaviour is not better accounted for by a manic episode.
Before you go any further in this workbook, consider the following…

**DSM-5**

As part of the DSM-5’s proposal to re-label substance-related disorders to addiction and related disorders, pathological gambling has moved from impulse control disorder to addiction and related disorders and renamed as gambling disorder.

<table>
<thead>
<tr>
<th>Will this potential move for gambling disorder be good? Record your impressions.</th>
</tr>
</thead>
</table>
LEARNING ACTIVITY – Scenario about Vicki

Vicki is a 70 year old married European woman who emigrated to NZ about 3 years ago. She retired from a senior management position seven years ago. She was referred by the Gambling Helpline when she stated that she has had a pre-existing problem with gambling since she retired. She has spent $4,000 in the past four weeks out of an annual income of between $30,000 to $50,000 which comes from retirement savings for her and her husband. She plays the pokies daily for 2 to 3 hours losing about $1,000 per week.

Vicki has been on depression medication for the past three years for mild to moderate symptoms that have never had a review from her GP. She drinks a bottle of wine per day and more when socialising. Her relationship with her partner is not good, and she has low self-esteem and lacks self-confidence, which adds to her social isolation and lack of meaningful activities. She knows that not being able to control her gambling makes these matters worse.

What effects might Vicki’s problem gambling be having on her?
Internet addiction

Whether you choose the three subtypes described by Block or the five subtypes described by Young, the variants share the following components:

1. Excessive use, often associated with a loss of sense of time or a neglect of basic drives.
2. Withdrawal, including feelings of anger, tension and/or depression when the computer is inaccessible.
3. Tolerance, including the need for better computer equipment, more software or more hours of use.
4. Negative repercussions, including arguments, lying, poor achievement, social isolation and fatigue.

For functional impairment to daily life, disruption to daily and work-related tasks and interpersonal relationships is taken into consideration, as well as disruption to sleep patterns, eye and back strain and the risk of carpal tunnel syndrome. These functional impairments are often used to determine whether someone’s use of the internet is problematic.

Sex addiction

While explored for inclusion in the DSM-5 sex addiction was excluded largely because of the lack of empirical evidence. Even though sexual addiction is seen as an addiction within its own right, with or without the use of the internet, it is an example of how the virtual world and real world can merge.

Sex addiction includes masturbation, viewing pornography, sexual behaviour with consenting adults, cybersex, telephone sex, and/or strip clubs.

The proposed criteria for hypersexual disorder from the American Psychiatric Association although not included in the DSM-5 remain as important guidelines

A Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behaviour in association with four or more of the following five criteria:

1. Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behaviour.
2. Repetitively engaging in these sexual fantasies, urges, and behaviour in response to dysphoric mood states (eg anxiety, depression, boredom, irritability).
3. Repetitively engaging in sexual fantasies, urges, and behaviour in response to stressful life events.
4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behaviour.
5. Repetitively engaging in sexual behaviour while disregarding the risk for physical or emotional harm to self or others.
B There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behaviour.

C These sexual fantasies, urges, and behaviour are not due to direct physiological effects of exogenous substances (eg drugs of abuse or medications) or to Manic Episodes.

D The person is at least 18 years of age.

**LEARNING ACTIVITY – Scenario about Harry**

Harry is a senior manager in a large organisation and spends a lot of time at his desk at the computer. He has been accessing internet porn for a decade mostly at home but sometimes at work too, from shortly after the birth of his second child. He progressed to setting up meetings with prostitutes but his wife identified a motel receipt. She forgave him, but had to deal with a compulsory disclosure of an STD two years later. His wife recently again found evidence that Harry was accessing internet porn, resulting in “get counselling or get out”!

Harry presents with narcissistic traits and moderate depression. His worst thoughts are that his children may find out and think less of him and staff may think less of him.

What effects might Harry’s addiction be having on him?
Food addiction

Food addiction can have a biopsychosocial impact on individuals. They run a high risk of becoming overweight (excess weight for height) and physically obese – an excessively high amount of body fat in relation to lean body mass. Obesity carries with it potential complications to the heart, liver and blood pressure and it can lead to type 2 diabetes and some forms of cancer. With obesity comes a lack of physical movement that can compound weight gain, reduce energy and cause further physical complications.

From a psychological point of view, pre-existing emotional issues are relevant, as well as those resulting from the weight gained due to the addiction. Low self-esteem, depression and social isolation can develop. Social isolation often occurs as a result of the shame and stigma attached to being obese and feeling rejected socially.

LEARNING ACTIVITY – Scenario about Melanie

Melanie is 25 years old and works in an office. She was raised in a home where food was held in high regard as a way of being rewarded and loved. As a result, she was never skinny and often shied away from sports and boys in college. She has tried a few diets and gym memberships but nothing seems to last for very long as stress from work often makes her give in to her favourite foods. She now lives on her own and does not socialise much with people she works with. She makes every effort to not eat much during the day in front of her workmates but finds herself eating high calorie foods in the evening for comfort. She has gained considerable weight since living on her own which her family and friends have commented on. She struggles to find clothes that fit her which is starting to impact on the image she is expected to keep at the office.

What effects might Melanie’s food addiction be having on her?
**Work addiction**

Work addicts will be at risk of physical and mental health issues as they will lack self-awareness about attending to the balance needed between work and lifestyle. They use work to avoid intimacy, which will place co-worker relationships and personal relationships at risk.

Due to the lack of balance in their lives, work addicts could inevitably lose the very entity they place all their energy into. As symptoms increase, productivity can suffer placing great risk in jobs being lost.

**Shopping addiction**

For the shopping addict, they will become fixed on objects and purchases to determine their self-worth and emotional state. This will interfere with interpersonal relationships at work and home, and intimacy development. It also may lead to psychological symptoms such as depression and anxiety.

They will ruin their credit rating and live with anxieties of mounting debt. As they will be concealing their behaviour, they have no support in managing their money better. They may isolate themselves further by limiting access to where they live, for fear of being found out by other people seeing the purchases that have been made.

**Risk-taking**

Due to their impulsive nature, risk-takers can be vulnerable to responding to their environment in ways that can cause them negative consequences. Often with impulsivity, the anticipation of consequences before an event is fleeting and it is only after the fact that risk-takers will be faced with the impact of consequences. They may also minimise the consequences especially if they experienced more reward from their actions or had near misses, which may convince them to take future risks.

Risk-takers will potentially engage in criminal activities, develop substance and non-substance addictions, and be at risk of physical and psychological injury due to their actions.
Effects on the natural supports of users

When considering the impact on the natural supports of non-substance addictions, keep in mind the information provided in the substance addiction section on natural supports. As non-substances addictions are increasingly being seen as fitting into similar pathways to substance addictions, natural supports of substance and non-substance addicts will have similar experiences. Natural supports for people with non-substance addictions will be affected in physical, mental and social ways.

Problem gambling

For every problem gambler there are 5 to 10 people directly affected. Domestic violence has been linked to problem gambling, as well as emotional and financial distress. As problem gambling is often seen as the hidden disorder, natural supports may suspect something is wrong but do not know for sure until too late and their finances are in ruins.

Due to the shame and distortions about gambling, problem gamblers will deny anything is wrong until there is obvious evidence. They will often be convinced that they will recuperate their financial losses by continuing to gamble to pay their debts before anyone else needs to know. They may also be convinced that money has only been borrowed with intentions of returning it after a good win even when crime was involved to get access to the funds.

In the end, the financial burden lies heavily on the natural supports to remedy. Often a threat of violence also comes from people who are owed money and this can put natural supports in unsafe circumstances as well as the problem gambler.

Due to the emotional detachment that takes over problem gamblers to keep gambling when the consequences of their behaviour are mounting, family often suffer the emotional cost as well. They will experience the loss, fear of neglect and lack of emotional connection to the gambler. The isolation and shame will often lead to mental health symptoms for natural supports as well.

Internet addiction

For family members of someone with an internet addiction, even though it does not involve a substance or potentially leave them in financial ruin, the emotional impact is as intense as any other addiction. The isolation, shame and exclusion that family can feel may lead to their own psychological symptoms.

Often the increasing relationship with this medium will be at the expense of real life relationships and can lead to family breakups. Even employment and legal status could potentially be in jeopardy, which could impact greatly on the family.
Schneider’s 2000 work (Effects of cybersex addiction on the family: Results of a survey in *Sexual Addiction and Compulsivity*) surveyed families affected by cybersex addiction and found that 30% of the partners revealed that prior to cybersex the addicted had pre-existing compulsive sexual behaviours.

Overall, partners learning of cybersex taking place felt betrayed, hurt and rejected, which lead to a quarter of them deciding to separate or divorce. It was as difficult to accept as if it were an offline relationship. Often the cybersex was directly related to a significant decrease in couples having relational sex; partners would often feel in competition and hopeless compared to online sex. For the children in these circumstances, they are at risk of being exposed to cyberporn and objectification. They witness the parental conflict and experience the lack of attention.

**Sex addiction**

The partner of someone with a sex addiction will feel a strong sense of betrayal, rejection, isolation and self-doubt. They will feel unloved and that sex with other partners or through other means is more important to their partner than their love and relationship intimacy. They will often feel a sense of inadequacy, that their partner has not been sexually satisfied in their relationship. Significant emotional impact could lead to psychological symptoms such as depression. If unresolved emotions persist, relationships are at significant risk of terminating, which in turn can affect all family members if this occurs.

Partners of sex addicts are also at great risk of contracting sexually transmitted diseases (STD). Because risk-taking can be part of the sex addiction, sex addicts will often place themselves and any other sexual partner at risk of exposure to STD if protection is not taken. For many partners, they may not know of the sex addiction encounters until it is too late to protect themselves physically.

**Food addiction**

Food addiction can impact greatly on natural supports. They witness the change in a person’s body image and self-esteem, and struggle to know how to help. Pointing out the negative changes they see can sometimes only make the behaviour worse. They feel powerless over their fears of what will happen to this person if the behaviour does not stop and how this will impact on the person’s life expectancy.

This addiction may start to influence the health of natural supports. Their mental health may start to suffer as part of the isolation and shame they begin to feel about these circumstances. In particular, children may be impacted by the modelling of this behaviour by an adult to the point where they begin to engage in similar eating patterns with similar foods and start to personally experience the negative consequences as well.
Re-read the scenario about Vicki, on page 68.

What effects might Vicki’s problem gambling have on her husband?

Re-read the scenario about Harry, on page 70.

What effects might Harry’s addiction have on his wife and other family members?
Re-read the scenario about Melanie, on page 71.

What effects might Melanie’s food addiction have on her relationship with her family and friends?
Work addiction
Even though much time is spent in the work environment, work addicts may have very poor work relationships. They will likely be poor team players, which will cause distance between them and their co-workers. Resentments may also build if co-workers need to make up for a work addict’s lack of productivity or excessive expectations, and are pressured into spending more time at work as well.

At home, loved ones will feel neglected and be affected by the lack of intimacy, which may lead to relationship dysfunctions. They will be frustrated that the extra time and effort at work is not meeting any family needs.

Shopping addiction
Loved ones of a shopping addict may be exposed to the addict’s irritability and excess moodiness. If the behaviour is still concealed, loved ones will be wondering and making assumptions about why they see the addict behaving this way. This can lead to misunderstanding and arguments. When the behaviour is exposed, loved ones will be emotionally affected with anger, mistrust and disappointment, which could also lead to relationship breakdowns.

Due to the behaviour impacting on money management, natural supports may have to address the debt directly. They may become vigilant about challenging unaccounted for absences and purchases from the addict, which could lead to their own psychological symptoms brought on by the stress of the addiction.

Risk-taking
Risk-takers may attempt to draw others into risky behaviours with them, placing others in compromising circumstances that could lead to physical and psychological consequences. Criminal activity may lead to legal ramifications.

For significant others, they may be on the receiving end of the consequences of the risk-taker’s behaviour. They may be placed in positions where they have to pick up the pieces of the risk-taker’s actions. The impulsive and unpredictable nature of the risk-taker can place loved ones in increasingly stressful situations. The loved ones can be left feeling very worried about what the risk-taker may be involved in next, and may be concerned for that person’s welfare.
Suggested answers page 60
The problem-severity continuum – gambling

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>At casino, pokies jackpot winner shouts food and drinks to friends.</td>
<td>1</td>
<td>Normal social behaviour.</td>
</tr>
<tr>
<td>Has great “system” with horses, says he is going to make lots of money.</td>
<td>5</td>
<td>As gambling progresses, often have erroneous beliefs.</td>
</tr>
<tr>
<td>Has money in lots of different envelopes in her handbag and uses one for</td>
<td>5**</td>
<td>Money separation common strategy to control spending.</td>
</tr>
<tr>
<td>Can’t afford to get car out of casino car park.</td>
<td>5</td>
<td>More serious if regular event.</td>
</tr>
<tr>
<td>Argues with cashiers at the track for being slow, missing bets and making</td>
<td>7</td>
<td>As gambling problems progress, blaming others for losses is common.</td>
</tr>
<tr>
<td>Argues with family/whānau members about placing more bets.</td>
<td>6</td>
<td>Gambling is affecting others.</td>
</tr>
<tr>
<td>Well dressed, shows no emotion when places large bets or picks up large</td>
<td>4**</td>
<td>May be affluent, use others’ money, or may be “professional”.</td>
</tr>
<tr>
<td>Spends more and more time at the TAB and is becoming more scruffy/unshaven.</td>
<td>6**</td>
<td>Needs to be an indicator over time.</td>
</tr>
<tr>
<td>Argues with another customer using their favourite machine after it wins.</td>
<td>5</td>
<td>Belief they have a special relationship with machine/entitled.</td>
</tr>
<tr>
<td>He looks stressed while placing his last bets and has trouble getting</td>
<td>5</td>
<td>Betting more than he can afford; gambling causing problems.</td>
</tr>
<tr>
<td>Asks for credit at the TAB for the last race, promises he’ll pay it all</td>
<td>7</td>
<td>Likely to be aware that TAB credit is against policy – desperation.</td>
</tr>
<tr>
<td>Leaves child in car while gambling, for several hours.</td>
<td>7</td>
<td>Taking great risk for child’s safety, likely lost track of time, compromised responsibility.</td>
</tr>
<tr>
<td>Plays two machines at the same time.</td>
<td>7</td>
<td>Indicates escalating gambling.</td>
</tr>
</tbody>
</table>

Note: Relative severity is a guide only. Actual severity depends on assessment.

Note: *insufficient information  ** needs additional indicators to be sure
Types of addictive behaviour

Theories of addiction

There are several theories of addiction that form an understanding of addictive behaviours. For example, addiction has been understood through a combination of genetic and environmental factors. There are strong beliefs that if alcoholism runs in the family then the offspring are at much higher risk of being genetically predisposed to developing the same behavioural response when consuming alcohol. The disease model and the basis of Alcoholics Anonymous assume problems with alcohol are caused by a personal abnormality which is irreversible, and can only be managed by complete abstinence. Biological models have a similar approach, that predisposing physiology or physical withdrawal effects determine addictive use. But, environmental factors suggest that the experiences people have and the environments that they are exposed to have equal relevance to whether addictions will develop.

Jacobs takes into consideration both factors in his article “A general theory of addictions”. He describes addiction as a dependent state that is acquired over time to relieve stress, and that two interrelated sets of factors predispose people to addiction. The first factor is an abnormal physiological resting state and secondly, childhood experiences that produce a deep sense of inadequacy. Emotional vulnerability is often used to understand the reasons for addictive behaviour. Whether predisposing or as part of the psychological withdrawal process, people have been known to use substances or reward-seeking behaviours to self-medicate and escape unpleasant emotions. In combination, all these models form the basis for the biopsychosocial model, which acknowledges that interacting influences of biological, social and psychological factors affect the individual to influence the development of an addictive process.

However, behavioural models suggest that no predisposing stressors are necessary to develop addictive behaviours. The belief system here is that classical conditioning through cues and positive reinforcement encourage “operant conditioning”, which is to do the behaviour more frequently, usually without understanding why it is happening. So subjective excitement and physiological arousal will be understood through irrational beliefs and illusions of control that lead to addictive behaviours (Blaszczynski and Nower, 2002). This response is often coupled with increased accessibility and availability.

Types of addictive behaviour of addiction service users will be discussed through physical dependence, environmental and psychological factors and behavioural conditioning.

References
Addiction, 97.
Motivating factors and characteristics of types of addictive behaviour

Tobacco use is recognised in the DSM-5 as potentially leading to tobacco use disorder. Only approximately 5% of those who use cigarettes do not become addicted and most smokers want to quit but do not feel they can. Because of the rapid effect and short lasting process, it quickly can lead to being a habit or addiction.

Take time here to put together all the information you know about nicotine.
Type 1 – Physical dependence

A person frequently throughout each day smokes cigarettes that they are highly addicted to, to achieve normal functioning.

Motivating factors

Cigarette smoking causes highly addictive physical dependence. If too much is taken in at any one time it can make a person feel unwell and they learn to reduce their dosage to a point that just keeps them from not going through any physical or psychological withdrawal symptoms.

Smoking is a habitual behaviour and tends to become strongly associated with times in the day and certain daily activities. For example, a smoke and a cup of coffee becomes a way of breaking up the working day, providing a rest and a reward. This habit becomes a motivating factor to continue smoking.

Initially, the motivating factors to use may have been to fit in with the social norm of peers, keep thin and to enhance relaxing. However, as smoking can be used throughout the day in many environments, even with the Smoke-free Act in effect, it forms a habit response that can be associated with many situations throughout the day.

Characteristics of addictive behaviour

Because of the highly addictive nature of nicotine, people will be preoccupied with anticipating when they will be able to organise their next smoking hit. They will ensure they have cigarettes on them at all times or know of an easy way to access them. They will ensure money goes towards their smoking at the expense of other basic needs. They will need to ensure that they have access to cigarettes for throughout the night and first thing in the morning.

The majority of people who smoke addictively want to quit but choose to attempt it by going “cold turkey”. Most relapse in the first week and at the one year mark only about 2.5% will have maintained abstinence. People make several attempts at smoking cessation this way, only to be discouraged each time.

Often during these attempts, people will find themselves secretly returning to smoking without wanting to tell anyone due to the embarrassment. This very discouraging outcome can create a defeatist response where people accept that the consequences of this addiction will be their downfall, which may cause them to smoke even more often.

For others, they will deny or minimise the problem as a maladaptive way of psychologically coping to not have to face how difficult this will be to sort out. These people might say they could quit if they wanted to but choose not to, just to keep from lowering their self-esteem.
LEARNING ACTIVITY

Consider another substance that might become so addictive and create such physical dependence that it is needed to achieve some form of normal functioning. We often see this occurring with opiate injecting and alcohol addictions, so pick one of these to work through motivating factors and characteristics of addictive behaviour.

What would be the motivating factors and characteristics of addictive behaviour for the substance you have chosen?
Within the DSM-5 are the criteria for substance use disorder. Depending on the frequency of substance use, and the progressive nature of addiction, use will move along the continuum from mild to moderate to severe use.

Take time here to put together all the information you know about alcohol use disorder.
Type 2 – Environmental and psychological factors

A person continues to engage in harmful drinking behaviour despite the consequences to themselves and others who care about them.

Motivating factors

Environmental issues can be highly influential when considering the motivating factors for alcohol abuse. Initially, alcohol use and experimenting with some level of intoxication is associated with having a good time, letting off some built up tension, fitting in with peers and being sociable. Feeling more socially acceptable can be a very important motivating factor especially for someone who has difficulty fitting in with others.

The company a person keeps can also dictate the level of alcohol consumption expected. If it is important to have a sense of belonging with a particular group of people, then a person will consume what is expected, even if it causes them and others negative consequences.

If there are predisposing emotional issues or issues develop over the course of alcohol experimentation, people will become aware of the medicating effect of alcohol use. Due to the social acceptance of alcohol consumption, it is easy to convince oneself and others that they are only drinking sociably. More purposeful alcohol consumption can lead to signs of dependence.

Characteristics of addictive behaviour

For people who abuse alcohol in social situations, they may end up in fights that they cannot remember having the next day or end up with a legal charge against them for assault or drinking and driving. It may have not been their intention to drink so much. Instead of owning responsibility for their consumption getting out of control, they may rationalise and say it was the alcohol that caused it and was just bad luck or they were provoked by someone else.

If the person’s alcohol consumption begins to cause negative consequences within the social circles they keep, they may be rejected and will start looking for other groups of people that are drinking at the increased levels they are now able to tolerate. Excuses will be made for why they do not hang out with the old crowd anymore, such as, the others are boring and not any fun anymore.

For people who drink for emotional relief, they may keep finding increasing opportunities to go to events that allow alcohol consumption, which also gives permission to have a few drinks before and after going out. You may also see this person starting to drink home alone in between social events.
LEARNING ACTIVITY

Consider another substance that a person might continue to engage in despite the negative consequences to themselves and others that care about them. We often see this occurring with cannabis or amphetamine use, so pick one of these to work through motivating factors and characteristics of addictive behaviour.

What would be the motivating factors and characteristics of addictive behaviour for the substance you have chosen?

<table>
<thead>
<tr>
<th>Motivating Factors</th>
<th>Characteristics</th>
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People can develop an addiction to the pokies within weeks of playing them on a regular basis. Machines only take seconds to determine a loss or win and with consecutive play this speeds up the development of an addiction. Machines also have a return rate of approximately 90% which gives the illusion of winning.

Take time here to put together all the information you know about problem gambling.
Type 3 – Behavioural conditioning

A person feels compelled to play the pokies no matter how much money they have lost playing them.

Motivating factors

Initially, people experiment with playing the pokies as part of their night out at the pub or club. In between socialising and having a meal and a few drinks, people will have a flutter on the pokie machines. People who develop addictions to the pokies often remember their first win as something that was unexpected and pleasurable and will continue to be motivated to play to get the same “buzz” feeling that they did when they first won. Even if the problem gambler is not winning, they will draw motivation and pleasure from the anticipation of winning.

Once a problem gambler becomes aware of the debt that is mounting from their pokie abuse, they will continue to be motivated to play as a way of regaining their money back. Pokie machines also cause a switching off or escape effect. When playing them people can lose track of time and space, which for many is a relief from the other problems in their life or from the problems that playing the pokies is causing them.

Characteristics of addictive behaviour

Because of the behavioural conditioning that can occur with playing the pokies, it can defy understanding. As a coping mechanism, people who are addicted to the pokies will be drawn to irrational beliefs and illusions of control to make sense of why they are compelled to play them. They will minimise the amount of money they have lost as a way of rationalising their continued play, even when confronted by family and friends. This often leads to concealing from loved ones that they are still playing the machines.

Even though winning on the pokies is a completely random event, people will believe that they have some way of controlling the machines paying out and will continue to put more money in until they have no more funds. This often leads to accessing money through illegal means just to keep playing.
LEARNING ACTIVITY

Consider another behaviour that a person feels compelled to engage in no matter what the costs are. We often see this occurring with other forms of gambling or other behavioural addictions, so pick one to work through motivating factors and characteristics of addictive behaviour.

<table>
<thead>
<tr>
<th>What would be the motivating factors and characteristics of addictive behaviour for the behaviour addiction you have chosen?</th>
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Actions to address addictive behaviour

When considering actions that can be taken to address addictive behaviour, it is important to consider the process and readiness to change. The model describing the process of change was developed in the addiction treatment sector in 1993 by Prochaska and DiClemente and has come to be widely used. Their model gives insight into the types of actions to take place and the way they should take place based on the readiness of the person.

The model pictured below details a process based upon the idea of how people come to a decision to make change and highlights that it is not a finite process. It indicates that motivation fluctuates, and it can be a guide in terms of what action may be most appropriate according to the stage of change a person is at. It also importantly offers a very hopeful perspective, this is, that regardless of how many times someone may have attempted change, there is always the chance for them to move back around the cycle again into action and maintenance. This is why the model is often referred to as “The wheel of change”.

![Transtheoretical Model of Behaviour Change](image)
**Action 1 that may be taken to address addictive behaviour**

When considering actions to address high physical dependence, pharmacotherapy can be highly effective. In terms of perception, people may be reluctant to consider medication to help with their addiction. Medication is not to be considered a magical cure, but it can offer relief from physical withdrawal symptoms and secure better health with periods of abstinence.

As an example, for stopping smoking, nicotine replacement therapy (NRT) plus support offers better success results than going “cold turkey” from smoking. NRT consists of gum, patches, nasal spray and inhalers. Prescription pills that reduce the withdrawal effects or control dopamine surges through their anti-depressant ability are zyban, champix and nortriptyline, which are subsidised by the government. For support, Quitline is also available.

Pharmacotherapy is also available for other substance addictions with high physical dependency, such as, naltrexone and methadone programmes for opiate addictions. Naltrexone has had some success for alcohol and problem gambling addictions and zyban has also been helpful with problem gambling. This is beneficial knowing that 60% of pathological gamblers are nicotine dependent.

**LEARNING ACTIVITY**

Take some time now to familiarise yourself with the prescription medicines mentioned by doing some of your own research. Also, as Quitline is a support for smoking cessation, find out what other help lines and support groups are available for other substance and non-substance addictions.

Research the prescription medicines mentioned and other help lines and support groups.
Action 2 that may be taken to address addictive behaviour

When considering actions to address abusive use of substances, it may be helpful to engage in some harm-reduction approaches, such as, self-monitoring exercises. Many people who use more than intended often say after the fact that they had no control over what happened and their impulses took over the situation. Self-monitoring exercises can be empowering because it helps the person to use their thinking responses which has the power to control acting impulsively. It can also offer a more accurate reflection of amounts being used. Sometimes if a person knowingly realises they are using more than they thought, that alone could be a deterrent to excessive use. Harm reduction offers the ability for people to be invested in the decisions they want to make about change in their behaviour.

Education on drug use usually accompanies engaging in self-monitoring exercises, which a support person can assist with. Many people do not know the safe upper limits of alcohol consumption so they will feel more informed when considering this plan.

Following are some examples of self-monitoring exercises. As well as looking at amounts used, it also offers an opportunity to gain insight into patterns of when someone is more at risk and what triggers their abuse.

Creating your habit-breaking plan

Reasons for cutting down or stopping drinking

1

2

3

Dangerous situation 1

Ways of coping:

1

2
Dangerous situation 2

__________________________________________________________________________

Ways of coping:

1. ________________________________________________________________________

2. ________________________________________________________________________

Dangerous situation 3

__________________________________________________________________________

Ways of coping:

1. ________________________________________________________________________

2. ________________________________________________________________________

Ways of meeting others who don’t drink or do so within low-risk limits

1. ________________________________________________________________________

2. ________________________________________________________________________

Ways to try for avoiding boredom

1. ________________________________________________________________________

2. ________________________________________________________________________

How to remember your plan

1. ________________________________________________________________________

2. ________________________________________________________________________

Babor & Higgins-Biddle (2001)
<table>
<thead>
<tr>
<th>Day</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tr>
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<td>How I felt before</td>
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<tr>
<td>How I felt after</td>
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</tr>
</tbody>
</table>
LEARNING ACTIVITY

Take some time to review the self-monitoring options provided. Consider what editing would be necessary to make them useful for other substances and behavioural addictions.

Fill them in with answers you would like people to consider as you may be in a position where someone will need an example of what you are asking them to do.

Edit the self-monitoring exercises for other addictions and fill them in with example answers.
Action 3 that may be taken to address addictive behaviour

Brief interventions
Brief interventions are a valuable way of raising the issue of concern with someone who is unaware that there is a problem or is reluctant to get treatment. Brief interventions are opportunistic and can be just one conversation that can motivate the person to change their behaviour.

Brief interventions:
- Don’t just happen in therapy sessions.
- Work better when the problem has not become advanced, but can also work with severe problems.
- Focus upon improving the person’s motivation to change their behaviour.
- Aim to motivate to trigger a decision and a commitment to change.

It has been a persistent finding in addictions treatment research that relatively brief interventions of one to three sessions are comparable in impact to more extensive treatments.

An important aspect in helping people change or to consider change, is the provision of feedback to them from information they have provided you with. This is also an important principle for brief intervention.

Screens
The use of screens (a set of screening questions) becomes a valuable way of providing feedback to people about their substance use or behaviours. A screen can provide evidence of a problem that we may not have thought to cover, asks the right questions and may “sow a seed” towards preventing progression of a developing problem.

When engaging in discussion with a person about identifying issues of concern, it is important to present the topic of substances and behaviours in a non-judgemental and least-intrusive manner to reduce resistance. Assuming normalcy allows for more comfort in bringing up the subject and more open discussion offers the opportunity to inquire further about the use or behaviour.
For people who engage in alcohol or other drug use and gambling behaviours, positive outcomes are usually experienced; however, sometimes negative consequences can begin to develop for different reasons, one of which is that it can affect a person’s health or budgeting. In this instance, by framing the inquiry as health or budgeting-related rather than inquiry into lifestyle or admission of a substance or behaviour problem, it can raise interest in completing the screens. It is important to always make the inquiry relevant to the person.

It is important to indicate that screens are not diagnostic and they only indicate that further assessment may be appropriate based on the score results.

As a person’s guilt and shame can prevent acknowledgement of a problem, referring to the screen as suggesting that a problem may be evident, avoids labelling and externalises the problem, making the issue easier to address.

A person’s response to the screen results may be influenced by their level of personal concern. For instance:

- If a screen indicates further assessment and the person has been concerned themselves, then referring on for a further assessment is the appropriate intervention.
- If a person is not as personally concerned as the screen results are indicating, they may be willing to at least consider information that is offered.
- Offering support and ongoing monitoring are also valuable interventions.

Matching the appropriate intervention to the individual’s circumstances is very important. Addictions developed through behavioural conditioning may respond well to healthy obstacles being placed between the user and the cue. For example, for problem gamblers, issuing self-exclusion orders at gaming venues is a good harm-minimisation strategy or for someone with cyberporn or cybersex addictions, adding pornography blocking software to computers.

It is helpful to have screen tests available for a variety of substance and behavioural concerns. For example, a less threatening way to ask someone about their own gambling is to first ask if they have ever been affected by someone else’s gambling. On the following pages are screens ABACUS use for gambling and for internet sexual behaviours.

You can find out more about screens in the Careerforce workbook for US 27079.
Concerned Others Gambling Screen (COGS)

Sometimes someone else’s gambling can affect the health and well-being of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing, stressful and long-lasting. To help us identify if this is affecting your own well-being could you answer the questions below to the best of your ability.

1) Do you think you have ever been affected by someone else’s gambling?
   □ No, never *(you need not continue further)*
   □ I don’t know for sure if their gambling affected me
   □ Yes, in the past
   □ Yes, that’s happening to me now

2) How would you describe the effect of that person’s gambling on you now? *(tick one or more if they apply to you)*
   □ I worry about it sometimes
   □ It is affecting my health
   □ It is hard to talk with anyone about it
   □ I am concerned about my or my family’s safety
   □ I’m still paying for it financially
   □ It doesn’t affect me anymore

3) What would you like to happen? *(tick one or more)*
   □ I would like some information
   □ I would like to talk about it in confidence with someone
   □ I would like some support or help
   □ Nothing at this stage

**Scoring:** This is an awareness-raising instrument that also allows a person affected by another’s gambling to indicate what assistance they desire.

1. A “yes” to any one of the last three responses in question one identifies that the person may be adversely affected by another’s gambling.
2. Question two provides an opportunity for the person to identify any effect the gambling currently has on them, including those who say they “don’t know for sure” in question one, but disclose an effect when they think of it.
3. Responses to question three provide the intervention desired.

Developed by Dr Sean Sullivan – ABACUS Counselling, Training & Supervision Ltd – www.acts.co.nz
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes □</th>
<th>NO □</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you find lately that you are looking more often at sexual images on the internet?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you find that sexual images on the internet that you used to regard as stimulating now are starting to look tame or ordinary?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are thoughts of wanting to look at sexual images on the internet making it difficult for you to concentrate on other matters?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you find that looking at sexual images on the internet helps you forget your problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you tried to cut-down or stop looking at sexual images on the internet but have found it difficult to do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you searched out sexual images on the internet at work even though there is a rule that this is not allowed?</td>
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</tr>
<tr>
<td>7. Do you find that when you've finished looking at sex images on the internet that more time had passed than you had realised?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Would you prefer to masturbate looking at sexual images/pictures on the internet rather than engage in sex with a real partner?</td>
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</tbody>
</table>

**Scoring:** If you answer YES to two or more questions you may be developing problems around your use of internet pornography. Taking action now may reduce harm in the future.

Developed by Dr Sean Sullivan – ABACUS Counselling, Training & Supervision Ltd – www.acts.co.nz
LEARNING ACTIVITY

It is recommended that you try a few role-play practices with your peers to experience engaging in a brief intervention with someone. Practise introducing a screen and providing feedback to the person.

Practise role-plays and write your experiences here.
Completion and assessment

Congratulations!
You have come to the end of the workbook for Unit Standard 27076:

Describe common substance and non-substance addictions in New Zealand, their effects, and types of addictive behaviour.

Please check over all the activities in this workbook to make sure you have completed them.

Your assessment is next
You need to complete the trainee’s assessment successfully to be credited with this unit standard.

Your assessor will sign you off once you have completed the assessment tasks satisfactorily.

Your assessor is able to give you a “Certificate of completion” for achieving this unit standard.

Acknowledgements
Careerforce would like to thank the people who have contributed their time and effort into creating this workbook by:

- Research and content validation.
- Updating to the DSM-5
- Advice and expertise.
- Testing the activities.
- Sharing personal experiences.
- Appearing in photographs.

Disclaimer: The images contained in these workbooks are visual illustrations only and are not representative of actual events or personal circumstances.