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SUBSTANCE ABUSE : CAUSAL FACTORS AND TREATMENT

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SUMMARY

This paper utilizes observations and statistics from the case histories from Banyan House, a residential drug treatment program, in an attempt to expose the differences between the myths held as facts by the public and the real parameters and causes of the development of substance abuse by the individual. It includes a description of the treatment approach as it arises out of the perceived development of a substance abusing young adult. It brings to focus the family and parenting situations which appear to be precursors of substance abuse and suggests the possibility of identifying "high risk" individuals prior to the onset of substance abuse. Finally, it emphasizes the importance of the community accepting responsibility to find ways of providing help to parents and their children.

INTRODUCTION

This paper's aim is to highlight observed precursors and factors contributing to increased risk of drug abuse developing in the young in our Australian society. The statistics were drawn from the residential population seeking treatment at Banyan House, a therapeutic community under the auspices of the Forster Foundation for Drug Rehabilitation, for the period 1978 to 1985. Interestingly, Banyan House's population draws from all States and Territories of Australia and is representative of young, adult, Australian drug abusers.

The public knows that drug abuse is epidemic, yet remains abysmally ignorant of its nature and causes.

Drug abuse and abusers frighten people, and they resist learning about it. Most people feel helpless about the whole topic. Consequently, due to the selected information that the public is exposed to through the sensationalism of the media and our politicians, the public cling to certain myths about drug abuse and drug abusers; and until it affects them personally, they do not bother to seek more information.

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Myth Number 1: That drug abuse strikes any individual at random without causal factors and without precursors. It is therefore unforeseeable and thus unpreventable.

The FACT is that there are long standing precursors to drug abuse that place certain individuals and populations at higher risk of becoming drug abusers. Drug abuse is, therefore, predictable and thus preventable.

The precursors are obvious to those who work in the field of "habilitation" or "re-parenting" of drug abusers and the rehabilitation of alcoholics. These predictive factors constitute a profile of a drug abuser and are both personal and societal. They are evidenced in the following statistics.

The case histories of 154 residents of Banyan House containing self-reported and usually confirmed-by-other-data were studied (154 constitutes 68 per cent of the Banyan House population, 1978-1985).

Of the 154, 99 per cent reported one or more of the following factors occurring during childhood and formative adolescent years:

1) *Migrant* - family migrated to Australia during individual's childhood or just prior to birth of child.
   - Individual separated from family during childhood and moved to an Australian institution.
   - Individual arrived in Australia without family and remained isolated from family.

2) *Alcohol* - at least one parent perceived and experienced by the child as a practising alcoholic.

3) *Widow* - mother reared child/children alone due to natural father having died or abandoned mother prior to birth of child (i.e. father never known to child).
   - Father died during childhood or adolescent years.

4) *Parenting Deficits* - alienation from parent/parents due to lack of communication of positive feeling for the child, as perceived by the child.

5) *Deserted (Single Parent)* - both parents known to the child, however, separated, deserted or divorced and ceased parenting child/children together during childhood or adolescent years.

6) *Workaholic fathers* - father largely absent due to work involvement from the parenting situation during child rearing years.

7) *Orphaned* - without either parent throughout childhood due to being abandoned as an infant or due to both parents' deaths, either when an infant or during early childhood.

8) *Mother dead* - mother known to the child, however, died during childhood years.

9) *Incest* - natural father offender in every case.

10) *Sickness of Parent* - parental terminal illness lasting more than one year.

The above factors occurred both singly and in combination.

The following factors have not been mentioned singly, but do occur in combination with one or more of the above factors:

11) *Domestic violence* - physical abuse against mother or child or both.

12) *Institutional placement* - frequent institutionalisation from birth, early childhood, or adolescence for considerable periods of time.

13) *Left home early* - individual left the parental home at or before the age of 14 without further guardianship.

14) *Absent father* - father jailed or geographically distanced from family through individual's childhood years for extended periods.

15) *Elderly* - parents (usually father) over the age of 45 when the child was born and perceived by the child as disinterested in further child rearing.

Table 1. Predictive factors

No. of Defined Factors Evident	No. of Individuals	Percentage
0 factors	2	1
1 factor evident	60	39
2 factors evident	56	36
3 factors evident	30	20
4 factors evident	6	4
Total	154	100

Table 2. Number of individuals who cited defined factor

Defined factor	Single factor only	One of multiple factors	Total	Percentage
Migrant	23	41	64	41.55
Widow	11	21	32	20.77
Parenting deficit	9	23	32	20.77
Alcohol	3	26	29	18.83
Deserted (single parent)	5	24	29	18.83
Workaholic fathers	2	12	14	9.09
Orphaned	3	9	12	7.79
Mother dead	1	8	9	5.84
Incest	2	3	5	3.24
Parental sickness	1	2	3	1.94
Domestic violence	-	10	10	6.49
Institutions	-	10	10	6.49
Left home early	-	10	10	6.49
Absent father	-	8	8	5.19
Elderly	-	4	4	2.59

The obvious conclusions from the above statistics are that precursors exist in the parenting of the individual. The drug abusers we see are the victims of inadequate parenting - either personal or environmental or both. Given the consistency with which these factors appear, it is high time that the community:

a) recognize situations wherein any child is at risk or experiencing gross parental difficulty;

b) aid in improving the quality of the parenting to which the child is exposed.

Table 2 indicates that for approximately 42 per cent of the individual case histories studied, the "migrant" factor emerged. The individual in this category may not only experience separation and upheaval from known places, habits, lifestyle and language, but also, the child may feel alienated from, and ambivalent towards, parents and parental customs and injunctions and experience isolation and difficulty as an individual who is "different" and therefore not accepted by his or her peers. This "immigrant" status during the 1950s and 1960s was often also associated with poor socio-economic position and lack of opportunities.

The importance of the quality of fathering also emerges from the statistics and was observed to be of equal importance in the child-rearing of both males and females. The quality not only pertains to the father's presence but to his behaviour and modelling demonstrated in his alcohol-involvement, violence, sexual behaviour and general involvement in parenting. It was usually the father who was cited as the parent displaying the following factors: alcohol abuse, parenting deficit, absent (through desertion, criminality, age or work).

Public attention is too often focused on the parental socio-economic position of certain "revealed", young drug abusers, rather than on the quality of parenting that the position may have cost. To workers in the treatment field it is a constant observation that despite the claims of many drug abusers about their socio-economic backgrounds, it is most often, in reality, a background filled with lack of social and educatinal opportunities and consequent parental stress.

Myth Number 2: That a previously asymptomatic, mentally-and-emotionally healthy and adjusted youth becomes a drug abuser.

The FACT is that the at-risk young individual usually clearly demonstrates more than average difficulties and "symptoms of disease" in early adolescence, a long time prior to drug abuse. It is the existence and continuation of these personal and environmental characteristics that further inhibit the individual's development to full potential.

A couple of months ago on television, I was astounded to hear a professional in this field state that, with another drug substitution, a heroin addict could return to his previous "happy lifestyle". I have never seen a heroin abuser with a previously happy lifestyle - ever.

The usual profile of disturbance and being at-risk is evident in a change in school behaviour and a change in achievement and grades from Grade 7 to Grade 10.

It is important that this change is recognised as constituting a crisis.

A glaring fact, from self-reported data of the Banyan House population, is the poor scholastic attainment level and the degree of observed illiteracy of young drug abusers.

From the following table (Table 3) it can be seen that of the known population of 212 individuals, only 22 attended school in senior years, while 190 (89.62 per cent) left school at, or in the vast majority of cases, prior to the first certificate examination.

Table 3. Scholastic attainment of Banyan House residents 1978-1985

	Final Grade Attained at School								
Total resident number	Primary	Junior				Senior		Unknown
		Gr. 7	8	9	10	11	12	
226	6	9	39	85	51	21	1	4

These facts are puzzling when isolated amongst youth of at least average intelligence, and the educational deficit is experienced later as disaffecting.

The change in school interest, behaviour and grades commences at, or around, early pubescence and may very well be associated with the increased personal difficulties of coping with puberty, self-image, expectations and ideals, added to the lack of good parenting role models, respected disciplinary figures and controls which are of such vital significance for any individual's personal development and future in society.

Our population report that the onset of truancy, lack of interest, boredom, introduction and experimentation with drugs usage began at this time, and usually it culminated in the individual's leaving school prior to failure at the end of year examination and grading. This marks the first avoidance of a reality-test, and it appears to be the beginning of a pattern of lack of reality-testing, lack of completion and application, and self-delusion so

endemic among drug abusers. There is also a history of episodic depression or anti-social behaviour or both that commences around pubescence and is a long-standing personal difficulty for those people who later succumb to drug abuse. What is distressing is the current apparent lack of controls and interceding factors that are capable of arresting this process - to "nip it in the bud".

The above delineates the predictable, long-standing and recognizable antecedents of the onset of drug abuse.

Thus, public knowledge of, and early identification of symptoms, followed by intervention at this stage could prevent later development of drug abuse.

Myth Number 3: That the drug abuse is treated as the disease.

The FACT is that the substance abuse is the full-blown symptom of long-term underlying gross personal dysfunction affecting every area of life and personal development.

Statistics and observations reveal that treatment for substance abuse commences after the person has suffered for some years, and life is utterly unsatisfactory when honestly appraised.

The usual client profile on entry into treatment delineates:

1) disturbed family relationships;

2) minimal educational level achieved, i.e, high illiteracy;

3) continued history of under-achievement in work-skills and life-skills (sometimes this is manifested as a surprising lack of experience and ability to execute ordinary everyday tasks, as if not enough adult attention had been received as a child);

4) a "compensating" individual who is far less skilled and capable than he or she portrays and something of a myth creator.

Treatment entails a wholistic "re-parenting" wherein attention is given to developing the individual in areas perceived to be lacking:

* *educational opportunities* - always short-term, able to be achieved with relative ease, often commences with literacy and job-skills training;

* *teaching of survival skills* in this society, e.g., how to properly complete a job;

* *teaching of emotional skills and self-worth and communication*, e.g., that personal feelings, whether hurtful, frustrating, or joyful, can be experienced, expressed and survived without resorting to a state of incapacity and "not really being there".

Recovery after the experience of being a substance abuser is slow, developmental and relapse-prone. Perhaps not surprisingly, it parallels the maturation of a child to an adult.

Treatment after years of "substance abuse" living is a band-aid and is directly linked with exposure to a wider world of experience and the collection of confidence-giving adult skills - both attitudinal and reality-based.

Only when "normal" skills replace absent skills can a person reduce the necessity of the habit of "compensation" with its inherent self-delusion and dishonesty.

Observation of the recovery process reveals a period of about three years of development and consolidation to be necessary in an adult for future stability in regard to substance abuse.

It must be remembered that, in an adult, substance abuse has largely masked a very real lack of abilities and personal psychological disabilities. Perhaps this contributes to the difficulty of educating the public properly about the nature of substance abuse as to the very ordinary dysfunctions it really entails.

Treatment and recovery are an arduous battle, having to do with maturation and replacement of the substance abuse through the developing of skills and the grasping of presenting opportunities.

Perhaps the above explains the improved prognosis seen to exist for two groups, both well motivated and accessible:

1) those entering treatment young and with a short substance abuse history

and

2) those with a very long history who are absolutely determined that all in the substance abuse direction is repetition, i.e., observed maturation.

Myth Number 4: That alcoholism and other drug or substance abuse is separate, different and compartmentalized and that seriousness is related to the particular, preferred drug.

The FACT is that substance abuse has long been known by "users" and "treaters" to be multi-drug use and abuse in all combinations of legal and illegal drugs with the same aim and, hopefully, result and originates from similar causal factors and predispositions.

The legal status of any substance has very little bearing, if any, on the treatment necessary for recovery from a substance abusing lifestyle or the seriousness of one abused substance over another.

This seems to be a very hard fact for the public to appreciate and I feel it would really be of great benefit if only this fact were understood. It would open the door closed by fear and feelings of helplessness and could initiate the placement of substance abuse in its proper perspective.

Substance abuse is demonstrably linked between generations. We observe this in these statistics through the direct and indirect consequences of alcohol abusing parents, i.e., individuals (18 per cent) citing alcohol directly, with additional indirect involvement possible and probable in factors of widow, parenting deficit, deserted, workaholic fathers, orphaned, incest, parental sickness, domestic violence, institutional placement of child, child's leaving home early, and absent father.

This intergenerational link, whether learned behaviour through modelling and perceived by the child as coping with discomfort and stress or/and involving biochemical factors in addition, is demonstrated by repeated occurrence in treatment of the heroin abuser whose parent(s) is alcoholic or the petrol or the glue sniffer whose parent(s) is alcoholic or the alcoholic whose parent(s) is alcoholic.

There is a family generation link, and the particular substance or combination of substances abused is often the only element changed from one generation to the next.

This conference refers to "our changing society", and I feel we really need to face facts.

With increased availability of all abused substances, more "at risk" individuals are exposed to these substances, and the number of casualties will increase.

The absence of societal emphasis, recognition and aid given to the quality of parenting, by both parents and supported by extended family, friends and the community, permits the rampant paucity of parenting evidenced in this society to go unchecked, thus increasing the casualty situation of our children.

Unemployment of youth, youthful depression with reference to the person, his career and the world-future all contribute to the perceived lack of alternatives which would be preferable to drugs. Lack of education further limits opportunities and thus limits possible alternatives.

With only one-third of Australian families living in a nuclear family situation, our community has a challenge to meet:

a) To educate about the importance of parenting, family and community *responsibility*, and the part that is obviously played by the *quality* of parenting.

b) To provide *permitted support* for parents within our social structure and opportunity and provision for family treatment. Many people in our community are aware of young people suffering in their developmental years and would help if they felt able. So many times, good modelling and quality adult contact is not forthcoming due to shyness and perceived inappropriateness of contact, i.e., the feeling of intruding into another adult's privacy and parenting rights.

c) To "pick-up" those children showing "lead-up" symptoms from Grade 7 through to Grade 10, (e.g., truanting, a dropping-off in performance, a lack of interest and so forth) and offer them and their parents appropriate aid and support and direction.

We need to make some gains in this area of community health by becoming braver and perhaps more "intrusive" and by elevating our standards of personal and group responsibility. When you treat casualties, the causes shriek at you.