

Substance Use Disorders and Self-worth
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Is there a link between substance use disorders and self-worth? This position paper voices the opinion that there is a correlation between these two variables. The DSM IV-TR (First & Tasmen, 2004) identifies eleven major forms of substance related disorders along with multiple subdivisions of many of these disorders. Some of the major categories include: Alcohol, Amphetamine, Caffeine, Cannabis, Cocaine, Hallucinogens, Inhalants, Nicotine, Opioids, Phencyclidine, sedatives, etc.

The DSM generally identifies three levels of pathological use: substance dependence, substance abuse and substance intoxication, with substance dependence being considered the most severe. The diagnostic criteria for the various differential diagnosis depend on the substance use, results of use and the ramifications of the substance preferred by the user. However, across the spectrum of substance use disorders there must be “behavioral changes associated with more or less regular use of substances that affect the central nervous system” (DSM III, 1980, p. 492). These changes are normally considered undesirable by the general population but may be acceptable to certain sub-cultural groups. These unacceptable behavioral changes include, but are not limited to, an impairment of social or occupational functioning as a result of substance use and an inability to stop or control use of the substance and based upon the substance used and/or the development of serious withdrawal symptoms after reduction or cessation of substance use.

There are many other complications and/or associated disturbances which appear hand in hand with any chronic substance use. They may include physical deterioration, illnesses, vitamin deficiencies, psychological issues such as mood swings, paranoia, violence, sexual aggression or impotence, countercultural lifestyles, anxiety, depression and related disorders such as alcohol induced mood disorder (First & Tasman, 2004)

There appears to be no single unique personality, genetic or physical trait that is a necessary causal factor for substance use. Yet, there are at least two salient items that appear in an overwhelming majority of substance use cases. According to Hatterer (1984) compulsiveness is the key. The repetitive, compulsive drive to use substances is one method a person has to cope with unmanageable internal stress, conflict, pressure or stress. The second characteristic in the personality of the substance user/abuser is a low self-worth. Valliant says that substance abuse “is sometimes preceded and is always followed by profoundly low self-esteem” (as cited in Bean and Zinberg, 1981, p. 192). The reader should note that for this article, the terms self-esteem and self-worth are used interchangeably. For the purposes of this article, self-worth is defined as how a person views him/herself in terms of their acceptability to themselves. In plain language, does a person like and accept themselves with all of their positive and negative attributes. Positive self-worth is generated when a person feels that they have something intrinsically worthwhile to offer the world; and that something is themselves. This concept also assumes an acceptance of others, regardless of their “qualifications” as beings of worth. These others are worthy of respect, dignity and acceptance simply by virtue of their existence.

It is beyond the scope of this article to try to establish which developmental theory is the correct one for developing positive self-worth. However, one can accept that all developmental theories have a normal developmental sequence; one that probably starts with a healthy relationship with a primary care giver, then a differentiation of self from external reality through the various stages of developmental conflict to the final emergence of a human being who realizes that they are an independent entity with individual wants, needs, desire and self-worth.

Every major theorist recognizes the need for a healthy self-worth. Adler, Horney, Rogers, Ellis, May, Maslow, Erickson, et al. espouse the need to develop a good sense of

self-worth. Maslow (1970) says “all people in our society (with a few pathological exceptions) have a need or desire for a stable, firmly based, usually high evaluation of themselves, for self-respect or self-esteem and for the esteem of others (p. 74). Maslow further states that “satisfaction of the self-esteem need leads to feelings of self-confidence, worth, strength, capability and adequacy of being useful and necessary to the world” (p. 75).

Support for the concept that low self-worth may lead to substance use disorders comes from many diverse sources. For example, Kaplan (2004) noted a link between drug use and low self-worth, with heavier drug users having lower self-worth. A study on the effects of parental permission to date and its relationship to drug use linked self-worth to both the age parents allowed dating and to drug use (Wright, 1982).

Many theories on how we develop positive self worth have been hypothesized over the years (Santrock, 2004). Among these theories are certain central themes that appear to be both self-evident and recurring. Among them, self-worth must come from within. “We have been learning more and more of the dangers of basing self-esteem on the opinions of others” (Maslow, 1970, p. 80). The existentialists postulate that:

Being is not reducible to the introjections of social and ethical norms. The self-esteem based on a sense of being is not simply a reflection of others views of one. Although it involves social relatedness, it presupposes ‘eigenwelt’ the ‘own world’ of a sense of self identity or being-in-itself.” (Patterson, 1986, p. 117)

Early doses of “unconditional positive regard” directed at an infant and toddler appear to be very helpful in fostering positive self-worth (Santrock, 2004). Many substance abusers report, at best, a distant relationship with their parents. Many relate more pathological relationships, including constant criticism, harsh punishments, alienation and sometimes physical or sexual abuse. For many, the early alienation and lack of connectedness to the primary care giver carries

over into the child's social scene (Santrock, 2004). The child may feel left out in a social sense or perhaps is assigned the label of 'loner.' The desire for peer acceptance is one reason to start drug use, as is the self-medication to soothe the left out feelings.

These assumptions lead one to speculate on the types of treatment which would be most effective in dealing with the substance abusing population. After the denial, if any, is dealt with search for positive self-worth. Perhaps you may use the concept of reframing as described by Ivey and Ivey (2003). It is suggested that you add a significant amount of "unconditional positive regard." This acceptance and reframing seem to be especially useful in group settings. Alcoholics Anonymous (AA) has long been accepted as one of the effective treatments available to the alcoholic. It is interesting to see that in an AA meeting all persons present seem to view the other persons with acceptance and caring. This seems to be one of the more potent weapons in the AA arsenal.

In contrast, therapies that stress moralistic judgment and any form of aversion therapy seem contraindicated. These forms of treatment only tend to reinforce the substance user's poor self worth and their overall low self-worth.

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