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Exploring Substance Use Disorder: A Case Report

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Abstract

Substance Use Disorder (SUD) is a multifaceted mental health condition characterized by a challenging pattern of substance consumption, leading to impairment and distress across various areas of life. The current study presents the case of Mr. S, a 29-year-old with a history of alcohol and cigarette dependency originating from college, exacerbated by peer pressure and emotional challenges. Despite several rehabilitation attempts and supportive family involvement, Mr. S's struggle with SUD remains ongoing, underlining the chronic nature of substance abuse and the importance of sustained intervention. Through Cognitive Behavioral Therapy (CBT), pharmacotherapy, and support groups, Mr. S is currently undergoing treatment, though his recovery is marked by resistance and fluctuating engagement. This report emphasizes the need for integrated therapeutic approaches addressing both substance abuse

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and co-occurring psychological factors, such as depression and anxiety, which often complicate SUD cases. The literature highlights the role of family dynamics and early intervention as critical elements in recovery, while revealing gaps in the application of family-based treatment across diverse populations. Ultimately, the findings advocate for comprehensive, individualized care that addresses the psychological and social dimensions of SUD to foster long-term recovery and reduce relapse risk.

Keywords: *Alcohol and Cigarette Dependency, Depression and Anxiety in SUD, Substance use disorder.*

Introduction

Substance use disorder (SUD) is a condition, characterized by a pattern of pathological substance use, resulting in significant life problems or distress. SUD ranges across mild, moderate, and severe. An overwhelming compulsion to use the drug is going to occur; possibly along with withdrawal symptoms as well as an increased tolerance of its effects when an attempt to stop using the drug. Two of the possible kinds of substance use disorders that can occur simultaneously in one person are alcohol use disorder and cocaine use disorder. A substance use disorder may adversely affect the general quality of your life, relationships, and health. It may also pose a risk to life. You are therefore important to get treatment once you begin to note any signs of SUD.

About 65 percent of adults report high-risk drinking, which is exceeded daily recommendations at least once a week during the past 12 months. Alcohol is also the most commonly used drug among adults. It's particularly alarming because more than 10 percent of adults today binge drink, that is, four or more drinks for women and five or more for males on the same occasion.

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The is a 29-year male and holds B. Tech qualification in Haldwani who was having no job and had behavioural issues along with alcohol abuse and uncontrollable smoking since 2014 when he was brought. During college days, quite a great deal of pressures on studies was there, as well, the pressure was tremendous due to rivalry and friend pressure. After alcohol use and cigarette use started after the second year of the college, Mr. S began to get dependent rather rapidly. He used substances to cope with feelings of loneliness, promote social bonding and reduce anxiety, though it resulted in verbal aggression and severe disturbances in essential areas of life, which included blackout and family disturbance. Although Mr. S graduated in 2017, he never followed a job or education track and continued using substances. His mother started taking significant interest in his deteriorating condition and prompted him to seek admission at Sai Kripa Foundation, Haldwani, in 2022. While, he was there for a year, symptoms he displayed were weight gain, euphoria, agitation; however, not much improvement was seen in the total condition of the person. After the battle with his mother in the year 2024, he was sent to Sai Kripa Foundation located in Noida to attend treatment and get into recovery patterns. His family especially his mother has been of support to his treatment process despite him having a cold relation with his brother and having nobody close to him. This neutral approach by his family has been helpful in ensuring he copes with this condition.

Mr. S has no setup self-care routine and occupational engagement in terms of working. He resists the therapist, fidgets from head to toe, does not maintain eye contact, and was less cooperative during the first session. His premorbid personality was more active and calmer with better expression and engagement in hobbies. Substance use history, lack of routines, and family problems are cardinal influencers while attempting treatment for Mr. S. The transient improvement, followed by a relapse in 2024, underscores that his condition was chronic in nature with an ongoing need for therapeutic intervention over time.

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Mr. S has slumped posture and gait. He is dressed neatly as does his clothes and looks well-groomed with noticeable bruises on the forearms. He was clean. Social behaviour during the session included hand tremors and foot tapping, and eye contact was inconsistent. Answers also took some time. He would smile through the whole session. However, he would be stuck or would have a problem obeying a command or instruction. He was cooperative in his attitude, but at times seemed easily distracted. He was vigilant in his level of consciousness. Rapport was harmonious and cooperatively established, though he intermittently maintained eye contact. Orientation was intact, and psychomotor activity was within normal limits.

His speech was slow, low in volume, and nonspontaneous. It was circumstantial in coherence with halting fluency, a monotone tone, and delayed reaction time. Although he spoke enough, the content was limited. Mr. S's subjective report of his mood was "feeling good," but objectively, he appeared unhappy. His affect was incongruent, flat in intensity, restricted in range, and lacking fluctuation. Positive with stable and mild intensity of mood, limited reactivity, and sustained duration His thought processes were tangential. He was slow, especially as related to depressive content with further exploration needed for establishing abnormalities. Suicidal and homicidally he reported in the absence of such trends on observation. Attention was only mildly impaired. Memory seemed intact. Intellectual functioning came across as average. Insight was limited to his intellectual understanding. Judgment seemed absent.

Provisional Diagnosis

F10.2 - Mental and Behavioral disorders due to use of alcohol

F17.2 - Mental and Behavioral disorders due to use of tobacco

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Suggested Treatment

Treatment of Mr. S will be CBT, relapse prevention, pharmacotherapy, as well as support groups to involve all psychological and physiological factors affecting his substance use. It is hoped that, through CBT, Mr. S be able to point out maladaptive thoughts and behaviors by pinpointing substance use triggers, such as stressful social settings, academic pressure, or loneliness, and log these situations so that he will become more aware of his patterns. Techniques from MBSR will also be introduced so that Mr. S will have better management of stress with the help of mindfulness. It would encourage Mr. S to do short mindfulness exercises every day at times when stress is high. A suggested workout routine shall be provided that will help improve well-being and decrease stress based on the preferences of Mr. S, whether it is to be held outdoors or in the gym. CBT therapy sessions shall also include cognitive restructuring to help Mr. S replace negative thoughts that have been associated with issues of self-worth and stress with realistic, positive ones. Role-play exercises will be conducted in social situations where he is likely to be under peer pressure, and he will be encouraged to strengthen his refusal skills with an emphasis on creating an "exit strategy" in cases where he feels tempted to relapse.

The relapse prevention plan is designed to minimize Mr. S's risk of relapse and increase his confidence in maintaining sobriety. Together, he and his therapist will identify past failures, pinpoint high-risk situations-whether related to an examination or party-and teach ways to cope with the common loneliness of college life. He will learn to keep himself alert for early indicators of relapse: raised levels of stress, irritation, and urges, a checklist to facilitate regular monitoring of himself. To help with this, a "crisis toolkit" will be prepared for him, which includes emergency contacts, grounding techniques, distraction strategies, and reminding him of his sobriety goals. In times of temptation, Mr. S will be encouraged to contact his support group or reach out to a mentor for immediate help.

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Physiological dependencies will be dealt with through pharmacotherapy, such as reducing cravings for substances. For smoking, options in terms of nicotine replacement therapy include gum, lozenges, or patches are discussed for the purpose of gradually reducing dependency. Its progress monitored; the dose is increased monthly. For alcohol misuse, Disulfiram, with proper informed consent, helps prevent drinking due to aversive effects if the patient should drink. Other interventions may include the use of a low-dose Naltrexone protocol, which helps to minimize the craving but does not provide intoxication effects. However, there are follow-ups during which the dosage can be adjusted if necessary and encouraged adherence.

Finally, getting involved with a support group will give Mr. S. a feeling of belonging and accountability. Besides, his attendance in regular meetings held at a rehabilitation center will help him to get rid of isolation and the peer insight he receives as a result of being with these people. He will work on a stronger commitment toward sobriety. Reinforcing this network, Mr. S. will have an accountability partner from this group, with whom he will encourage each other. Further, additional resources will be availed to get him linked to local support groups such as Alcoholics Anonymous or SMART Recovery. This will continue to fortify the support system for him. As add-ons to these activities, engagement in non-substance-based community activities such as volunteering, sports, or hobby groups will be encouraged as ways of providing healthy positive social environments that promote healthy sober living.

Prognosis

Several complicating factors make guarded the prognosis for Mr. S's recovery:

Long history of use: The use of substances began when he was in college, and it has become ingrained.

Relapse: He had a recent relapse in 2024; this emphasizes that his condition is chronic.

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Poor insight & judgment: Mr. S has poor insight and lacks judgment that would allow him to commit to recovery.

Drug Resistance: His avoidance behaviour towards therapy sessions and disengagement with any kind of therapeutic intervention can further complicate his recovery.

Family Network Support: While Mr. S's family, most noticeably his mother, are cooperating, their "balanced response" may not serve this case well, considering a case like Mr. S's. Strengthening involvement from the family-based sector is likely to yield more success.

Research Evidence

The analyses consistently highlighted broad consequences for personal, occupational, and public health where impact variation is seen strongly in terms of industry categories. Studies show that occupation in highly demanding work such as miners and workers in construction industry or those in the industries in accommodation and food service have significant and more severe substance use while variables that include job strain, easy access to the drugs and social culture facilitate its increase. Rates of heavy alcohol and illicit drug use, as measured by NSDUH for 2008-2012, were higher than average among full-time workers in those sectors. This further suggests that intervention targeting specific workplaces is an urgent need in order to curb the losses due to SUDs, related losses to productivity and workplace injury/absenteeism. Thus, the finding focuses attention on targeted occupational health approaches to minimize productivity effects of substance use among the industries with the higher risk.

Regarding the case history, substance use usually involves comorbid conditions of SAD and depression. Here, the case study showed how substance use may play a role as an incorrect coping mechanism to manage episodes of SAD and episodes of depression in the 20-year-old male patient involved. This case reflects more general epidemiological patterns that indicate

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high comorbidity of SUDs with mental health disorders among youth and young adults, complicating the trajectory of treatment and recovery. The response to CBT in this patient is an example of the potential of targeted mental health interventions to reduce causal symptoms of substance use and enhance functional outcomes that are likely to be accompanied by better social and occupational integration. It therefore follows that comorbid mental health disorders require interventions during substance use treatment to increase the sustainability and quality of recovery.

Conclusion

The case of Mr. S highlights the complexities of treating substance use disorder (SUD) and underscores the need for comprehensive, sustained therapeutic interventions. Despite various treatment attempts-Cognitive Behavioral Therapy, pharmacotherapy, and support groups-Mr. S still suffers from co-occurring psychological issues, lack of cooperation in treatment, and shifting participation. This is one example of the chronic, relapsing nature of SUD, where recovery patterns are influenced by many other factors, such as the influence of peers, the dynamics of the family system, and mental health problems.

It supports individualized, integrated treatment approaches that integrate behavioral therapy with family and social support systems in the treatment of SUD in order to better address the underlying psychological contributors. Early intervention and culturally tailored family-based models also need to be implemented in order to more effectively assist diverse populations. This case illustrates that an effective cure for SUD strikes at the very core of both the physical addiction and associated mental and social correlates and hence is associated with more permanent recovery and lower relapse probabilities.

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