AMI ROKACH

DRUG WITHDRAWAL AND COPING WITH LONELINESS

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ABSTRACT. Loneliness is a prevailing experience which is particularly familiar to adolescents and young adults. It is a subjective experience which is influenced by one's personality, life experiences, and situational variables. The present study examined the influence of drug cessation on coping with loneliness. Drug abusers, during their stay in detox centers, were compared to drug abusers who participated in a methadone maintenance program and those two groups were compared to a group of adults in the general population who are non users of drugs. A total of 304 participants volunteered to answer a 34-item yes/no questionnaire, reflecting on their loneliness experiences and how they coped with it. The factors which compose the *beneficial* coping strategies are: Acceptance and reflection, Self-development and understanding, Social support network, Distancing and denial, Religion and faith, and Increased activity. Results indicated significant differences in the manner in which the three groups cope with loneliness.

INTRODUCTION

Recent studies suggest that a large proportion of the population are frequently lonely (Rokach and Brock, 1997). Ornish (1998) stated at the very beginning of his book *Love and Survival*: "Our survival depends on the healing power of love, intimacy, and relationships. Physically. Emotionally. Spiritually. As individuals. As communities. As a culture. Perhaps even as a species." (p. 1). And indeed, loneliness has been linked to depression, anxiety and interpersonal hostility (Hansson et al., 1986; Lau and Kong, 1999), to drug and alcohol abuse (McWhirter, 1990), to an increased vulnerability to health problems (Jones et al., 1990), and even to suicide (Cutrona, 1982; Tundo and Baldessarini, 2001).

Rook (1988) observed that loneliness results from the interaction of person factors and situational constraints. That interaction is

closely associated with the changing circumstances which one encounters when learning to use drugs.

Akerlind and Hornquist (1992) maintained that “man is a social creature, totally dependent on the group for his or her development and survival as a human being” (p. 405). They also noted the significant increase in substance abuse, toward the beginning of the 21st century (see also Newcomb and Bentler, 1988; MacNeil et al., 2000). Drug abuse is one of the greatest challenges of our time, considered by some to be an epidemic (Shedler and Block, 1990; Goldberg, 1999). It has commonly been observed that the use of various substances interferes with, or impairs, physical, psychological or emotional functioning (see Ferguson and Hornwood, 1997; Pedersen and Skrondal, 1999). Although drug consumption is a way of “fitting in” and joining one’s peers recreationally (Weider and Kaplan, 1975; Akerlind and Hornquist, 1992), different substances effect the individual differently and are consumed to fulfill, at times, opposing needs (i.e., “uppers” vs. “downers”).

Deutch (1967) observed that drug addiction is often employed as a strategy to lessen the pain of emotional deprivation and social alienation. White (1991) asserted that substance abuse is particularly evident in those who are socially uncomfortable, suffer from anxiety, low self-esteem, mild to moderate depression and a lower than normal degree of social conformity. It was observed that amphetamines, methedrine and cocaine seem to increase the awareness of drive-feeling and diminish fatigue (Weider and Kaplan, 1975). MDMA (a.k.a. Ecstasy) on the other hand, is widely viewed as helpful in lowering one’s inhibitions and facilitating social intercourse (Akerlind and Hornquist, 1992). Furthermore, these authors concluded that “dependence on drugs is, accordingly, an actual substitute for dependence on others” (p. 407). Thombs (1999) further stated that one of the functions drugs fulfill is to facilitate social interaction, interpersonal communication, and self-disclosure.

Drug abuse affects society in many ways. It is costly in terms of hampering one’s work performance and attendance, it brings about crime and violence in neighborhoods where drug dealers congregate, it disrupts the family life of drug users, and of course affects the drug user himself mentally, emotionally, socially and vocationally (Sussman and Ames, 2001; Cherry et al., 2002). It is, then, not surprising

that there is pressure on the drug user to confront and control his addiction.

Detoxification, or as it is commonly referred to 'detox', is considered the first stage of treatment (Kleber, 1999). Detoxification usually (although not necessarily always) takes place in an inpatient setting. Inpatient detox maximizes the control which staff has on the addict's access to drugs or other craving-inducing stimuli, the patient can be closely observed for medical or other complications of drug withdrawal, and if a comprehensive treatment program is available family, vocational, medical and/or psychiatric issues can be addressed.

Methadone is a long-acting opiod, or narcotic medication, that represents an effective and legal substitute for heroin or other opiates. Methadone Maintenance (MM) is designed for those addicted to heroin and other narcotics. MM is based on the observation that "all narcotic analgesics may be substituted for one another with sufficient adjustment in dose and route of administration" (Gerstein, 1999, p. 136). Methadone, a drug, is effective orally, yields a fairly even effect across a 24-hour period, and is thus suitable for a regimen of single daily maintenance doses, and that greatly facilitates an outpatient approach to treating drug dependence (Senay, 1999). The MM programs are offered by federally licenced clinics, may last for up to two years and often include psychotherapeutic and vocational assessment and counseling. Gerstein (1999) reported that research yielded promising results on the MM treatment effectiveness in curbing drug abuse.

Substance abuse has been found to relate to higher tolerance of deviance (Brook et al., 1982), low self-esteem (Botvin and Eng, 1982), and to loneliness (Olmstead et al. 1991). Related to loneliness, according to Olmstead et al. (1991), is the notion of social support, which has been shown to be negatively related to drug use (Newcomb and Bentler, 1988).

Being closely related to drug abuse, and no doubt experienced during the difficult withdrawal period, it is of clinical importance to gain an understanding of the manner in which those ceasing to use drugs cope with loneliness, so it can be utilized in treatment programs, and thus facilitate drug cessation. The present study compared coping strategies of addicts in a detoxification facility, to those in a MM program, and to the way the general population copes with loneliness.

METHOD

Participants

Three hundred and four participants volunteered to answer the loneliness questionnaire. Sixty-five men were on a MM program, 77 were undergoing detoxification and 162 participants were not from amongst the self-identified drug users, and represented the general population.

The average age of all participants was 33.74 years with ages ranging between 19 to 86. The mean level of education (i.e., last grade completed) was 13.21 with a range of 1–23. Sixty percent of the participants were single, 20% married, and 20% have had a relationship but were no longer in it due to separation, divorce or death of a spouse. Table I provides a more detailed breakdown of age, education, and marital status within each group.

Procedure

Participants were asked to reflect on their loneliness experiences and to endorse those items which described the strategies they used to cope successfully with its pain. They took approximately 10 minutes to answer the questionnaire. In an attempt to overcome the methodological difficulty of other studies which relied solely on college students (see Vincenzi and Grabosky, 1987; McWhirter, 1990), the general population participants in the present study were recruited in urban Canadian centers from all walks of life. They were recruited in high schools, universities, shopping malls, and local centers where adolescents and young adults congregate. They identified themselves, on the questionnaire, as non drug users.

The “Rehab” participants were recruited from a local rehabilitation program which offered drug abusers Methadone in conjunction with a variety of individual and group therapeutic interventions, tapping such issues as life skills, depression, anxiety and relational difficulties.

The “Detox” participants were recruited from a local detox center which provided a period of detoxification to active drug users who either walked in or were referred, and who were under the influence of drugs when they joined the center.

TABLE I
Demographics

Population	N	Marital status			Education		Age	
		Single	Married	Divorced	M	SD	M	SD
Rehab (Re)	65	18	31	16	11.95 (6–17)	2.49	36.43 (21–59)	8.03
Detox (De)	77	46	4	26	10.80 (1–17)	2.94	34.96 (19–65)	8.59
Gen.Pop (GP)	162	119	26	17	14.80 (1–23)	2.62	32.09 (19–86)	18.82
Total	304	183 [60%]	61 [20%]	59 [20%]	13.21 (1–23)	3.21	33.74 (19–86)	14.96

* $p < 0.001$.
 $X^2_{(2,2)}(\text{mar.stat. by group}) = 66.37^*$; Bonferroni, Re;De;Gp.
 $F_{(2,297)}(\text{educ. by group}) = 65.77^*$; Bonferroni, Re;De;Gp.
 $F_{(2,297)}(\text{age by group}) = 2.32$.

The Loneliness Questionnaire

All items for the questionnaire were written by the author and based on Rokach's previous research on loneliness (Rokach, 1990). That study yielded a theoretical model of loneliness as reported by 526 subjects who were asked to describe the strategies which they employed in coping with loneliness and which proved to be beneficial to them. The present items were chosen from those descriptions and were modified to provide clarity and gender neutrality. The first draft was reviewed by six psychologists and two psychology students for any items or instructions which might be lacking in clarity, relevance, or content. The questionnaire was then constructed incorporating this feedback. The questionnaire has 86 items which describe a variety of *beneficial* coping strategies. The general instructions requested that participants reflect on their previous experiences of loneliness and endorse the items which described the coping strategies that were most helpful to them. They were assured of anonymity and were not asked to identify themselves.

Principal components factor analysis with varimax rotation was applied to the data with 0.40 being designated as the minimum loading for an item. The factor analytic procedure, using an SPSS program, extracted the principal components, and the factor matrix was then subjected to varimax rotation. The items contributing to the factors could be assigned meaning, and each accounted for a sufficient amount of the variance (at least 3%) to support statistical meaningfulness. The remaining factors accounted for 1 or 2% of the variance and so were ignored. Accordingly, repetitions of the varimax rotations were limited to five factors each to permit the results to be restricted to the most robust factors. Factor 1, Reflection and acceptance (accounted for 14% of the variance) – being by one's self to become acquainted with one's fears, wishes and needs; and consequently, accepting one's loneliness and its resultant pain; Factor 2, Self-development and understanding (5%) – the increased self-intimacy, renewal, and growth which are often the results of active participation in organized focused groups or of receiving professional help and support; Factor 3, Social support network (4%) – the re-establishing of social support network which can help one feel connected to and valued by other; Factor 4, Distancing and denial (3%) – denial of the experience and pain of loneliness by alcoholism, drug

abuse, and other deviant behaviors; Factor 5, Religion and faith (3%) – the need to connect to and worship a divine entity. Through affiliation with a religious group and practising its faith one can gain strength, inner peace, and a sense of community and belonging; and Factor 6, Increased activity (3%) – active pursuit of daily responsibilities as well as fun-filled solitary or group activities, thus maximizing one's social contacts. Each of the six factors comprised a subscale and participants' scores are the sum of items which they endorsed in each subscale. Although the original questionnaire included 86 items, due to participant's past feedback about its length, it was shortened and only the six highest loading items in each subscale were included; hence, the questionnaire included a total of 34 items (factor 5 includes only 4 items). Kuder- Richardson internal consistency reliabilities were calculated and yielded the following alpha values: $F_1 = 0.66$; $F_2 = 0.52$; $F_3 = 0.67$; $F_4 = 0.67$; $F_5 = 0.71$; $F_6 = 0.59$. K-R alpha for the 36 item questionnaire was 0.81 (See appendix A for sample items).

RESULTS

Table I illustrates the breakdown of age, marital status, and educational level within each group. Age ($F_{(2,301)} = 2.32$ n.s.) was not significantly different between the three groups while education ($F_{(2,297)} = 65.77$; $p < 0.05$) and marital status ($X^2_{(2,2)} = 66.37$; $p < 0.001$) were found to be significantly different amongst the three groups. A post-hoc Bonferroni test indicated that each of the three groups differed significantly from the other two in, both, marital status and education. Consequently, education and marital status were covaried in later analyses.

A MANCOVA was calculated in order to examine the overall differences between the variables, taking into account the inter-correlations between them. It yielded significant differences in the coping strategies amongst the three subgroups ($F_{(12, 580)} = 9.31$; $p < 0.001$). ANCOVA's were then calculated in order to examine, in more detail, those differences. Results of the present study indicate that, overall, the detox group had the highest mean subscale scores on the Self-development and understanding and on the Distancing and denial. No significant differences in the mean scores were observed in any of the other subscales (see Table II).

DISCUSSION

The present study investigated the manner in which drug abusers, who were attempting to overcome their addiction, cope with loneliness. They were compared to a sample of non drug users from the general population. Results indicated that the three groups cope significantly differently with loneliness. However statistical significance was reached on only two subscales: Self-development and understanding and Distancing and denial, with the Detox sample having the highest mean subscale score, and the general population the lowest.

The present results were expected, especially since research continuously indicated that drug users are lonely to a greater extent than the regular population. (See Akerlind and Hornquist, 1992; Daley and Salloum, 1999). It is suggested that loneliness is indeed rampant amongst drug users, possibly because they do not cope with it effectively and, thus, coping which may be comparable to that of the general population (which is not burdened by drug abuse, marginalization and social isolation to such a degree as drug users are) is insufficient to satisfactorily deal with loneliness.

Self-development and understanding is a cluster of coping strategies which encompasses increased self-intimacy, renewal and growth which are often the result of active participation in organized focus groups (i.e., Alcoholics or Narcotics Anonymous) and of receiving professional help and support. As was previously mentioned, those in Detox and MM treatment programs are regularly supported and encouraged to consult with professionals and further their understanding into what propelled them to abuse drugs. It appears that the more professional help the drug users received – the more they considered Self-development and understanding as helpful in coping with loneliness.

Shedler and Block (1990) suggested that drug users feel socially isolated and possibly alienated from their own needs and feelings. Senay (1999) pointed out that drug users have been found to use denial to a much greater extent than the general population. Consequently, the present results supported that view by finding that Distancing and denial are endorsed by the Detox sample to a much larger extent than by the other two groups. It is suggested that being in the throes of physical and emotional pain, such as is often experienced during detoxification, denial may actually be a beneficial strategy in

TABLE II
Comparing mean subscale scores of coping with loneliness by group

Population	N	Reflection and acceptance		Self-development and understanding		Social support network		Distancing and denial		Religion and faith		Increased activity	
		M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Rehab (Re)	65	1.98	1.47	1.23	1.18	1.51	1.5	2.13	1.47	0.60	0.88	1.41	1.32
Detox (De)	77	2.12	1.99	1.36	1.18	1.56	1.61	2.58	1.54	0.91	1.16	0.99	1.47
Gen.Pop (GP)	162	2.39	1.47	0.42	0.82	1.96	1.62	0.72	1.09	0.75	1.12	1.23	1.3
Total	304	2.37	1.62	0.83	1.10	1.76	1.60	1.50	1.55	0.76	1.09	1.21	1.36
Overall		$F^1_{(2,301)} = 1.78$		$F^1_{(2,301)} = 29.44^{***}$		$F^1_{(2,301)} = 2.75$		$F^1_{(2,301)} = 63.09^{***}$		$F^1_{(2,301)} = 1.44$		$F^1_{(2,301)} = 1.82$	
Manova													
$F^1_{(12,589)} = 9.91^{***}$													
Bonferroni													
						De;Re/Re;GP/De;GP = ALL				ALL			

* $p < 0.05$.

** $p < 0.01$.

*** $p < 0.001$.

¹ Marital status and education were covaried.

helping the addicts deal with their cravings. It may, therefore, also be seen as beneficial in helping them deal with the lonely and solitary experience of drug withdrawal.

Considerable diversity appears to exist among the coping strategies of the lonely (Rook, 1988), and as such, people differ in their readiness to recognize or admit (to themselves and to others) that they are in pain due to being lonely (Rook and Peplau, 1982; Booth, 1983). Feared stigma and loneliness anxiety – defending against the fear of experiencing loneliness (see Moustakas, 1972) – may result in attempts to deny the experience either outright or by distancing oneself from the pain, the consequent feelings of failure, and from the restlessness and desperation which loneliness entails (Rook, 1988). The Distancing and denial subscale addressed this issue and confirmed earlier observations of the connection found between loneliness and alcoholism, drug abuse and other behavioral disorders or deviant behaviors (Rook, 1984). As could be expected, the strategy of denial which is not promoted by the MM treatment, is similarly reduced in dealing with loneliness – although it is still significantly higher than in the general population.

Daley and Salloum (1999) pointed out that “family and social support systems play a critical role in ongoing recovery and are associated with improved recovery rates” (p. 259). It is, thus, surprising that no significant differences on the Social support network subscale were found amongst the three groups. The Social support network subscale depicted the reestablishment of social support network, of connecting with others and utilizing their support in dealing with loneliness and other life difficulties. Not only, as Ornish (1998) put it, our survival depends on others’ support, acceptance and love, but Berkmen (quoted in Ornish, 1998) observed that support is “about being embedded in the whole social system—in a society, in a community, in relationships—that is important . . . it is an interrelationship that is both giving and taking, which is what love is about, what intimacy is about” (p. 196). It is widely accepted by laymen and researchers alike that rebuilding one’s social network and establishing close relationships are among the most effective ways of coping with loneliness.

It is, therefore, suggested that although social support (by counsellors, medical personnel, and/or family members) may have been available to help drug users, they may have perceived it as helping

them give up drugs – rather than appreciate its effects in helping them cope with loneliness.

Prior research indicated that Reflection and acceptance is the most salient, widely used and beneficial strategy in coping with loneliness (Moustakas, 1961; Rokach, 2001). The reflection and acceptance subscale focused on using the opportunity of being by oneself and becoming aware of one's fears, wishes and needs as the most salient means of coping with loneliness. Moustakas (1972) and Mayer Gaev (1976) described loneliness as including a feeling of inner void, a detachment from one's self, and an alienation from one's core identity. As such, Reflection and acceptance, maintains that one cannot deal effectively with loneliness without a willingness to experience fear, anger, agony, and/or disillusionment. Loneliness may also precipitate a "joyous experience of self-discovery, a real meeting of self-to-self . . . it includes a sense of harmony and well-being . . . [and a way] of advancing life and coming alive in a relatively dead or stagnant world" (Moustakas, 1972, p. 21). The present results, in essence, confirmed those prior observations and found that all three samples similarly benefited from this strategy in addressing loneliness.

Rokach (1988) noted that "in our limitless and awesome universe, which humans have not fully grasped, under harsh social conditions and high personal expectations, a feeling of self-alienation, emptiness and a sense of meaninglessness are almost inevitable" (p. 243). Religion and faith, appear to address such feelings as it suggests that individuals need to feel connected to and/or worship a divine entity, God or a Supreme Being. Through affiliating with religious groups and practising their faith, individuals gain strength, inner peace and a sense of community and belonging.

Andre (1991) suggested that one may successfully deal with loneliness by finding solace, that "emotional experience of a soothing presence. In a turbulent world solace calms us. In the face of adversity it gives us composure" (p. 108). The present study found no significant differences amongst the three samples in turning to a higher power in seeking solace from loneliness. As is common in Alcoholics Anonymous (AA) programs, it is quite possible that drug addicts do use prayers during their attempts at drug cessation – alas, they may perceive it as aimed at dealing with their drug addictions [as is the case with AA and NA] rather than as a way of coping with the loneliness which they experience. Similarly, no significant differences amongst

the three samples were found on the Increased activity subscale which addresses active pursuit of daily responsibilities as well as fun-filled solitary or group activities. We may intuitively expect that drug users, during withdrawal, would substitute drug consumption and attendance at the subculture's various drug related activities, with other more socially condoned daily involvements. Those activities, which are practiced by the population at large, are similarly beneficial to drug users (see Oh, 2000).

In conclusion, drug users during their journey of withdrawing from drugs, do indeed cope differently from the general population with the experience of loneliness – and perceive especially Self-development and understanding and Distancing and denial as helpful strategies. In line with Weider and Kaplan's (1975) finding that users do not choose their drug of choice randomly, but choose the appropriate drug which fulfills their particular needs, it would be useful for future research to compare whether the drug of choice influences the manner in which one copes with loneliness, rather than [as the present researcher has done] grouping the heterogeneous population of drug abusers into one sample. Future research may also compare the influence of gender, age and socioeconomic status on coping with loneliness.

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APPENDIX A

Coping with Loneliness - Sample Items

Factor 1: Reflection and acceptance

I came to accept how I felt (0.59)*

I turned loneliness into a time for reflection (0.61)

I came to view being alone as an opportunity to think things through and set new goals for myself (0.64)

I tried to focus on what really mattered to me I life (0.59)

Factor 2: Self-development and understanding

I sought professional help from a medical doctor (0.57)

I actively sought to make new friends at social groups I attended (0.40)

I enrolled in personal development seminars (0.51)

I went back to work after years of being at home (0.41)

Factor 3: Social support network

I renewed old friendships (0.49)

I spent time at places where I knew there would be a lot of people (0.45)

I went to more parties and social functions (0.63)

I correspond with friends/family more frequently (0.42)

Factor 4: Distancing and denial

I denied to myself that anything was wrong (0.48)

I purposely built walls around myself (0.55)

I avoided social functions (0.40)

I drank alcohol to excess (0.58)

Factor 5: Religion and faith

I sought answers to my problems in prayer (0.75)

My attendance at religious services increased (0.68)

I felt strengthened and comforted by my faith in God (0.76)

I actively sought to make friends at my church (0.56)

Factor 6: Increased activity

I took up a new hobby (0.51)

I got a part-time job (0.42)

I took up a new sport (0.46)

I immersed myself in work (0.53)

*The factor loading of the item.

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*The Institute for the Study and Treatment of Psychosocial Stress 104
Combe Ave.*

Toronto, Ontario, Canada M3H 4J9

E-mail: arokach@yorku.ca