

Personal Characteristics of Chemically Dependent Individuals with Varying Degrees of Narcotic Anosognosia

Marina Markendudi

National University of Uzbekistan named after M. Ulugbek, Tashkent, Uzbekistan

Keywords Psychoactive Substances (PAS), Anosognosia, Internal Picture Chemical Dependence, Total and Partial Anosognosia.

Abstract This article focuses on investigating the personal characteristics of chemically dependent individuals with different levels of drug anosognosia. Our study revealed that the severity of anosognosia is directly linked to the personal traits of chemically dependent individuals. Moreover, narcotic anosognosia serves as a psychological defence mechanism and a coping strategy for dealing with addiction. The identified aspects of the internal perception of dependence on psychoactive substances can serve as differential diagnostic criteria when determining the appropriate psycho-correctional approaches for chemically dependent individuals.

1 INTRODUCTION

At present, due to the widespread use of psychoactive substances in the world, chemical addiction psychologists face a serious task - to shift from merely providing drug-related and suggestive assistance to chemically dependent individuals, and adopt a comprehensive integrated approach. This approach primarily involves bringing about positive changes in the consciousness of people suffering from chemical dependence and mobilizing their personal resources to confront their addiction to psychoactive substances. This approach focuses on addressing the core clinical phenomenon that sustains dependence on psychoactive substances, known as narcotic anosognosia. Before delving into this phenomenon, it is important to define the term "anosognosia." Anosognosia, derived from the Greek word "anosognosia" which means "denial of knowledge about the disease," is a neuropsychiatric syndrome characterized by a decrease or lack of critical assessment of patients regarding their health problems. It refers to the clinical phenomenon where the patient denies, ignores, or underestimates their own illness. The disorder was first described in 1899 by the Austrian psycho-neurologist G. Anton in blind patients after a stroke who believed they could see, and later observed by the French physician Joseph

Babinsky in patients with hemiplegia who were not aware of their motor defect. This condition is now known as the Anton-Babinsky syndrome, commonly referred to as anosognosia [7, p. 965]. Anosognosia occurs in 10-17% of patients in the acute period of stroke, about 40% in Alzheimer's disease, and 43-76% in alcoholism and drug addiction. Underestimation of one's own health condition may be associated with the phenomenon of psychological defence in chemically dependent individuals without structural brain damage. Anosognosia is relative and can vary over time, with a person sometimes acknowledging their illness and other times being unable to do so. This fluctuation in awareness is characteristic of anosognosia [8].

Anosognosia is commonly associated with various conditions such as neurological pathologies (neuro-infections, stroke, cerebral atherosclerosis, poisoning with neurotropic poisons like mercury and carbon monoxide), mental disorders (dementia, Alzheimer's disease, manic syndrome, etc.), somatic and psychosomatic pathology (arterial hypertension, peptic ulcer, tuberculosis infection, HIV, oncology, viral hepatitis), and chronic intoxication (alcoholism, substance abuse, drug addiction) [Ponizovsky PA(2006), p.111]. The exact pathophysiological mechanisms of anosognosia remain debatable, but it is noted that the lack of critical assessment of one's

* Corresponding author

own condition is not a result of decreased intelligence or dementia.

Various theories provide insights into anosognosia. The psychogenic theory views anosognosia as an unconscious psychological defence mechanism against information that causes anxiety, guilt, or distress. Through denial, chemically dependent individuals attempt to shield themselves from threats to their self-perception and emotional well-being caused by their condition. At a neurophysiological level, anosognosia is explained by an increased threshold of susceptibility of neocortical neurons to signals from the limbic system structures. While initially serving as a means of psychological protection, anosognosia later hinders the development of necessary adaptive mechanisms and adequate cognitive and emotional reactions to the disease, becoming a maladaptive form of behavior. Psychophysiological theories consider sensory and cognitive deficits as contributing factors to anosognosia. Sensory disorders result from impaired proprioceptive sensitivity and an inadequate perception of the body and its physical dysfunctions. Some theories propose that selective cognitive deficits, deterioration of regulatory functions, and impaired interhemispheric interaction may lead to the rejection of information about the disease [Ponizovsky PA(2006), p.52]. Lack of awareness of one's condition can be expressed in various forms, including total anosognosia (complete non-recognition of the problem without any arguments) and partial anosognosia (partial denial of the disease based on evidence).

Substance addicts often deny the existence of their chemical dependence and provide various justifications for their use ("I only use soft drugs," "soft drugs are legal in many developed countries, so they are not dangerous," "I can stop whenever I want"). They tend to shift responsibility for their addiction to those around them, usually their close relatives.

Anosognosia is diagnosed using psychological methods, such as questionnaires and interviews.

The purpose of this study is to examine the personal characteristics of chemically dependent individuals with varying degrees of awareness of their dependence on psychoactive substances.

2 METHODS

Investigating the phenomenon of anosognosia, we encountered a lack of literature on the study of

anosognosia among individuals suffering from psychoactive substance dependence. Most of the existing literature focuses on anosognosia in people with alcohol dependence, leaving limited descriptions of drug anosognosia and its semantic structure. The specific manifestations of awareness impairment in different categories of individuals dependent on psychoactive substances remain undescribed. Moreover, there is a lack of evidence-based data regarding the application of new psychological examination methods to diagnose narcotic anosognosia. To address this gap, we drew upon the works of E.I. Bechtel [Bechtel E.E. (1986), p.23-25] and L.I. Wasserman [Wasserman L.I., Eryshev O.F., Klubova E.B. (1993), p.13-22], which explore alcohol anosognosia as a system of psychological defence mechanisms enabling individuals to cope with internal psychological conflicts.

The psychodiagnostic stage of our study involved examining the personal qualities of the subjects and their interpersonal relationships. We employed a combination of clinical-psychological and experimental-psychological methods. The clinical and psychological approach entailed investigating patients' attitudes towards their disease through a structured interview we developed. As for experimental psychological methods, we utilized the following techniques: To determine the personality model of the subjects, we used the method developed by J. Oldham and L. Morris to determine their "type of personality" and the probability of disorders associated with that type. To assess the level of reactive anxiety (as a state) and personal anxiety (as a stable characteristic), we employed a scale for assessing reactive and personal anxiety developed by C.D. Spielberger and adapted by Yu.L. Khanin. For diagnosing mental states and personality traits, we utilized a depression scale adapted by T. I. Balashova. The statistical analysis of the results involved employing mathematical statistics methods, such as correlation analysis, factor analysis, and the method for determining the reliability of statistical differences using Student's t-test. We processed the results using the SPSS 11.0 and Excel 2003 computer programs.

Our study was conducted in narcological clinics in the city of Tashkent and involved examining 300 chemically dependent respondents, comprising 272 men and 28 women. The age of the subjects ranged from 18 to 65 years, with the largest age group being 23 to 40 years (comprising 65% of the sample). Among the respondents, 20% were hospitalized for the first time, while 75% had one to ten previous hospitalizations. The subjects' experience of using

psychoactive substances ranged from 1 to 5 years. Of the total sample, 160 were voluntarily undergoing rehabilitation, and 140 were in compulsory treatment. Regarding education, 37% of the sample had higher education, 42% had secondary-special education, and 21% had secondary education. Psychological diagnostics took place on the seventh day of the patients' clinic stay, after the main symptoms of the withdrawal syndrome had been alleviated. The control group consisted of 300 subjects who were students of higher educational institutions and did not have chemical dependence.

3 RESULT AND DISCUSSION

In chemically dependent subjects with total drug anosognosia, we observed high values in various areas, such as personal anxiety, infantilization, aggressiveness, sensitivity, self-confidence, and depression. These indicators may suggest an active suppression of events and facts that are unacceptable to the individual. Total drug anosognosia helps maintain self-esteem and protects the social status of chemically dependent individuals, while also significantly reducing anxiety and contributing to a prolonged, relatively "quiet" course of addiction. Furthermore, subjects with total anosognosia tend to display a clear sense of "emptiness" in their lives and a sense of "alienation." Chemically dependent individuals with total drug anosognosia exhibit extremely low scores in problem-solving abilities.

All of the above prevents the realization of the progressive nature of the disease as a subjectively more complex task, leading instead to simple and accessible replacements that are acted upon. Consequently, pronounced conflicts arise, including strong protests, leaving home, various manipulative behaviours, and demonstrative suicide attempts.

When contrasting the "self" of drug addicts with complete denial of the disease, we observe an extreme underdevelopment of semantic connections, limited comprehension context, and relatively low activity of thought processes. The ideas these individuals hold about themselves are superficial and overly exaggerated, while their understanding of drug addiction is highly distorted. Despite their narcotic anosognosia (denial of dependence), their ideas about drugs are similar to their ideas about themselves. This indicates a lack of intrapersonal conflict and critical thinking towards their dependence on psychoactive substances.

On the other hand, chemically dependent individuals with partial narcotic anosognosia exhibit less prevalence of depressive states, personal and reactive anxiety, infantilization, and manipulative behaviours in their relationships with others. Instead, positive interactions with people around them are noticeable. These individuals allow some information about their addiction to become conscious, but the semantic regulation of their actions appears to be simplified, contradictory, and not well understood.

In chemically dependent subjects who are aware of their dependence on psychoactive substances, we observe different personal characteristics, such as altruism, conscientiousness, devotion, activity, acceptance, self-acceptance, and goal-oriented behavior for personal growth. In this category, individuals tend to allow the realization of their dependence, and the system of their semantic connections is more developed compared to drug addicts with other forms of drug anosognosia. The internal conflict that arises upon realizing their dependence is not as relevant due to its almost complete resolution, which becomes possible through the complete disidentification of their ideas about themselves and their lives from ideas about drug addiction.

4 CONCLUSION

Concluding the study, we can assert that chemically dependent individuals with total drug anosognosia lack a significant internal picture of their addiction. On the other hand, those with partial drug anosognosia mostly have a limited cognitive component, while the emotional aspect tends to be positive towards the drug-dependent lifestyle, resulting in a discord between these facets of self-awareness and leading to an internal personal conflict. The complete formation of the internal picture of addiction is observed only in drug addicts who are aware of their dependence. In this case, the cognitive component reflects realistic perceptions of drugs, the emotional component shows a negative attitude towards the drug-dependent lifestyle, and the behavioural component is focused on achieving alternative, positive, and socially significant objectives.

REFERENCES

- Bechtel E.E. (1986). *Prenosological forms of alcohol abuse*. M.: Medicine, P.23-25

- Wasserman L.I., Eryshev O.F., Klubova E.B. (1993). Attitude to the disease, alcoholic anosognosia and mechanisms of psychological protection in patients with alcoholism // Review of psychiatry and medical sciences. psychology them. V.M. Bekhterev. No. 3. P. 13–22
- Impaired awareness of the disease in focal lesions of the brain/ Grigoryeva V. N., Sagildina A. O., Karova N. A(2011)..// Journal of Neurology and Psychiatry. S.S. Korsakov. - p.111
- Somatic anosognosia in patients with alcohol dependence/ Ponizovsky PA(2006). // Social and clinical psychiatry. p.52.Gallagher S. Philosophical conceptions of the self: implications for cognitive science. Trends in Cognitive Sciences. 2000;4:14–21. [PubMed] [Google Scholar] [Ref list]
- Besharati, S., Forkel, S. J., Kopelman, M., Solms, M., Jenkinson, P. M., & Fotopoulou, A. (2014). The affective modulation of motor awareness in anosognosia for hemiplegia: behavioural and lesion evidence. *Cortex; a journal devoted to the study of the nervous system and behavior*, 61, 127–140. <https://doi.org/10.1016/j.cortex.2014.08.016>
- Major R. H., (1954) History of medicine, v. 2, Springfield, p. 965.

