Self-Medication & Emotional Pain

Understanding the short-term relief that can keep a painful cycle going.

Self-medication describes using alcohol, drugs or another behaviour to change an uncomfortable internal state without addressing what is underneath it. The relief can be very real: anxiety may quieten, memories may feel further away, sleep may come more easily, or numbness may replace emotional pain. That short-term effect is exactly why the pattern can become powerful. Understanding the function of the behaviour helps us respond with more than judgement.

What might somebody be trying to manage?

Underlying experience	What the substance or behaviour may seem to offer
Anxiety / panic	Slowing thoughts, reducing physical tension, feeling more socially confident or escaping constant alertness.
Trauma / memories	Numbing, sleep, emotional distance or temporary relief from intrusive memories and hyperarousal.
Low mood / emptiness	Brief pleasure, stimulation, energy, connection or an escape from feeling nothing.
Loneliness / rejection	Belonging, confidence, company, distraction or relief from painful self-consciousness.
ADHD / overwhelm	Stimulation, slowing, focus, relief from restlessness or an attempt to regulate an overloaded nervous system.
Pain / insomnia	Temporary physical relief, sedation or a way to switch off when rest feels impossible.

Why short-term relief can become a cycle

When something rapidly reduces distress, the brain learns the association: pain appears, the person uses, distress falls. The next time the same feeling appears, the urge can arrive more quickly. Over time, tolerance may develop, the original problem may remain untreated, and consequences from substance use can add new anxiety, shame, conflict, debt, sleep problems or health concerns. The coping strategy then begins creating some of the pain it is being used to escape.

Self-medication is an explanation, not an excuse

Understanding why a behaviour developed does not mean ignoring harm. Someone can be responsible for the impact of their actions while also recognising that the pattern may have grown from attempts to survive distress. This distinction matters because shame often makes disclosure and treatment harder, whereas understanding function gives treatment something concrete to work with.

Signs the coping strategy is becoming costly

Using more often or in larger amounts; needing the substance before social situations, sleep or work; using alone; hiding use; repeatedly regretting what happens afterwards; worsening anxiety or mood between episodes; money or relationship problems; risky situations; tolerance; withdrawal; or feeling unable to face an emotion without using are all reasons to seek support.

Safety first

Do not assume abrupt stopping is safe after physical dependence. Alcohol withdrawal can be medically dangerous, and other substances have different risks. Reduced tolerance after a period of abstinence can also increase overdose risk if somebody returns to a previously used amount. Call **999** for unconsciousness, severe breathing problems, seizures, collapse or another immediate threat to life.

Understanding Your Own Cycle

The aim is not simply to remove a coping strategy, but to understand the need it has been meeting.

Map the sequence

1. Trigger	Conflict, memory, loneliness, pain, sensory overload, rejection, insomnia, pressure, boredom or another difficult state.
2. Internal response	Thoughts, body sensations and emotions intensify: “I cannot sit with this,” “I need to switch off,” or “I need something now.”
3. Self-medication	Alcohol, drugs or another behaviour provides rapid relief, stimulation, numbing or escape.
4. Short-term effect	The nervous system changes state. The relief reinforces the behaviour and makes it more likely to be repeated.
5. Longer-term cost	Rebound anxiety, low mood, withdrawal, poor sleep, shame, conflict, financial pressure or health problems increase vulnerability again.

Ask what the behaviour does, not only what it costs

Try completing: **“When I use, I am trying to…”** sleep, quieten my head, stop remembering, feel confident, reduce pain, stop feeling lonely, slow down, feel something, or get through the next few hours. Then ask: **“What else could meet even 10% of that need?”** Recovery becomes more realistic when alternatives are matched to the actual need.

A needs-based coping menu

For agitation: movement, cold or warm sensory input, paced breathing or a low-stimulation space. For loneliness: contact one safe person, use a peer group or spend time somewhere with gentle human contact. For intrusive memories: grounding and trauma-informed support. For insomnia: discuss sleep and substance use with a clinician rather than repeatedly sedating yourself. For emotional overload: reduce demands, eat, hydrate, rest and postpone non-urgent decisions.

The 20-minute bridge

When an urge appears, the goal does not have to be “never again.” Create a short bridge: delay for 20 minutes, move away from immediate access, contact somebody, change the environment and use one regulation strategy. At the end of the 20 minutes, reassess. Repeating short delays can create enough space for the intensity of an urge to change and for support to become reachable.

Track function rather than shame

For one week, record: **what happened beforehand; emotion; body sensation; thought; urge intensity; what you used or wanted to use; immediate effect; later effect; and what need you think you were trying to meet.** This is not a scorecard. It is information that can help identify treatment targets.

Trauma and emotional pain

Substance use and trauma frequently overlap, but trauma should not be assumed in every person who develops addiction. Where trauma is present, treatment needs to balance safety, stabilisation, substance-use support and appropriate trauma-focused work. Pushing somebody into detailed trauma processing before adequate safety and stability can be unhelpful.

Neurodivergence matters

ADHD and autistic people may use substances in attempts to regulate stimulation, social anxiety, sensory overload, sleep or emotional intensity. Support may need to include practical environmental changes, predictable routines, sensory strategies and treatment of co-occurring ADHD or mental-health difficulties rather than relying only on generic coping advice.

Moving From Relief Towards Recovery

Healthier coping works best when the underlying pain is taken seriously.

Treat both sides of the cycle

If treatment focuses only on stopping the substance while leaving panic, trauma, pain, loneliness or insomnia untouched, the original reason for self-medication remains. Equally, treating emotional pain while overlooking escalating substance use can miss immediate risks. Integrated care asks about both and builds a plan that addresses safety, dependence, mental health and daily life.

Professional support may include

Substance-use treatment	Assessment, keyworker support, harm reduction, relapse prevention, psychosocial treatment and medication for some forms of dependence.
Psychological therapy	Work with anxiety, depression, trauma, grief, shame, emotional regulation, relationships or the beliefs maintaining the cycle.
Physical health	Assessment of pain, sleep, withdrawal, medication, nutrition and other health effects that may be contributing to use.
Practical support	Housing, debt, employment, safeguarding and social connection can be central recovery issues rather than side problems.

UK routes to help

A GP can discuss physical health, mental health, sleep, pain, medication and substance use. Many local drug and alcohol services also accept self-referrals and can provide assessment, treatment and harm-reduction advice. FRANK offers confidential drug information on **0300 123 6600**. If there is an immediate threat to life, call **999**.

For someone supporting a loved one

Try replacing “Why are you doing this?” with “What happens for you just before you need it?” You can acknowledge the pain without approving harmful behaviour. Keep boundaries around safety, children, aggression, driving and shared money where necessary. Encourage professional support and remember that family members can seek help for themselves too.

One book to explore

***In the Realm of Hungry Ghosts* - Gabor Maté.** The book explores addiction through pain, trauma, attachment and human experience and is valued by many readers for its compassionate approach. Some of its broader explanations should not be treated as applying universally, so it is best read as one perspective alongside current clinical guidance.

A message from Maggie

Sometimes the first question is not “Why won't I stop?” but “What am I trying so hard not to feel?” The relief you get from a substance or behaviour may explain why it has become important, but it does not mean it is the only way you can cope. We can take the pain seriously and still look honestly at the cost. Recovery is not about taking coping away and leaving an empty space. It is about helping you build other ways to meet the need underneath it.

Clinical note & source framework

“Self-medication” is a descriptive concept rather than a standalone diagnosis. Substance-use disorders require individual assessment using recognised diagnostic criteria. Co-occurring mental-health conditions should be assessed rather than assumed to be caused by, or the cause of, substance use. UK information should be checked against current NICE guidance, NHS drug and alcohol treatment information, and substance-specific clinical guidance. Withdrawal and overdose risks vary by substance.