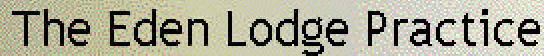

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Addictions: Towards an understanding: Part: 1:

An old fable:

Six blind men came upon an elephant, approaching an elephant from its side, the first proclaimed the elephant to be a wall. The second blind man feeling the tusk said the animal was more like a spear. The third reaching out felt the elephant's squirming trunk in his hands and declared this is most certainly a snake, whilst the fourth reaching out with both hands encountered the leg and said this beast is a tree. The fifth blind man reaching up encountered the elephant's ear and argued that the elephant was just a fan. The last approaching even more cautiously seized the elephant's tail, scoffed at the others and said it's nothing more than a rope.

These different opinions were discussed at length by the six blind men, with each one insisting that it was his opinion that was right; whereas in truth each was partly right, yet they were all wrong.

And so it seems today that addiction has many definitions some of which are partly right, and as pointed out by Joseph Dubey: *There are more theories about why we use drugs than there are drugs'*(1). A classic example being for alcohol addiction which some 60+ years ago had something like 40 different diagnostic definitions. (2). Today most people working with Alcohol or Other Drug (AOD) Misuse or Dependency rely on The Diagnostic and Statistical Manual of Mental Disorders(3), (DSM-1V). Or the International Classification of Diseases, (ICD-10)

In attempting to assist those with problems of addiction, I'm of the opinion that part of the misunderstanding is due in no small part, to the idea or theory that some drugs are physically addictive, whilst others are psychologically addictive, further that focusing on either, can and does distract from resolving the needs and issues of the person who has become addicted.

When the need for the drug(s) of choice becomes compulsive, to the extent that the user has an overwhelming urge to both acquire and use the drug(s), of his choice, he is not concerned about whether his urge is physical, and/or psychological, he is only aware of his needs. It is this compulsion that blinds

the user to all other considerations, regardless of whether those considerations, are moral, physical, financial, social, or domestic. The fact is that whatever drug(s) of choice the user has become dependent on, it has become the centre point of that person's life it has taken priority over everything else. Any personal values the user might once have had, are relegated by his need for his drug(s) of choice, therefore from that perspective addiction can be defined as a disease of the body, mind and soul.

The brain is the first organ to be affected by drugs, particularly alcohol, affecting that part of the brain that influences judgement, and behaviour; eventually this leads to distorted thinking which in turn can lead to verbal and visual, hallucinations, paranoia and schizophrenia. The need to fund his habit will lead to the user to rob, cheat and steal; it's no secret that most violent crime is AOD related.

Notwithstanding all the medical and scientific evidence pointing to addiction as a chronic relapsing disease, many people still have difficulty in accepting that it is a disease; indeed up until the 1950's our own Government classified alcoholics as vagrants, thereby stigmatising the condition, and so the stigma of addiction remains today, even some health professionals regarding it as a moral, or weak willed indulgence. The situation is not helped by social learning theorists, who have difficulty in acknowledging the evidence, preferring to ignore words such as addiction, in preference to describing the condition as a learned behaviour.

As a nation alcohol is part of our culture, we learn to use it at an early age, but we do not 'learn' to become addicted. Alcohol is a highly psycho-active drug, habitual and persistent use over a period of time can lead to dependency; if there is a history of dependency in the family, it will happen sooner, rather than latter, regardless of race, creed or class. Addiction is indiscriminate, it is not as social learning theorists suggest, the result of 'social deprivation'; nor is it necessarily because of abuse as a child, if it were, then everyone who had ever been abused at an early age, would be an addict, don't take my word for it, contact Alcoholics Anonymous, or Narcotics Anonymous, for details of 'open' meetings in your area, spend an hour of so in a few of those meeting and form your own conclusions.

Why then with the devastation that AOD misuse can cause do people choose to take potentially harmful drugs? There as almost as many theories of dependency, as there are definitions of it. Most people who drink have experienced a hangover, and vowed 'never again', yet sooner or later they repeat the experience, then they 'learn' that a 'hair of the dog' seems to make them feel better. Others repeat the same pattern experimenting with different drugs, and experience a sense of euphoria, when the inevitable downer comes, leaving a feeling of dysphoria, they 'self medicate' with more of the same; after all who wants to feel bad, when they can so easily feel good? One theory arising from the latter is that AOD users are seeking an altered state of consciousness without effort. It's also true that many people use AOD without becoming dependent, these people are described as 'recreational users' or

‘social drinkers’, but they too could be described in the same way; nevertheless, habitual use of any addictive drug will lead eventually to dependency, or what is sometimes referred to as substance abuse, the latter is sometimes defined as when the drug(s) of choice are costing more than money; a more accurate way of measuring abuse as opposed to dependence is shown in table 2:

Let’s now have a look at the four most commonly used drugs in this country, their psychological effects and the outcome of ‘self medication’:

Table: 1.

Drug.	Psychological Effects.	Withdrawal Affects/Symptoms.
Heroin.	Produces sense of well being: Tranquilises, together with ‘normalising’ influence on ‘disturbed’ feelings.	Internal disorganisation, intolerable aggression, relief of pain and anger, insomnia, hunger & depression.
Cannabis.	Calming & relaxing effect.	Mood swings, outbursts of temper, aggression, anger.
Cocaine	Increases feelings of energy, interest & excitement, and provides a strong sense of euphoria.	Lack of focus, almost unbearable boredom, depression, frustration, low self esteem, inattention, sometimes hyperactive
Alcohol.	Frees inhibitions, tranquillises, dissolves ego.	Feels uncomfortable in close personal situations, lacks self assertion, feelings of isolation & emptiness, feelings of guilt & shame, depressed and anxious

Of the four drugs listed, alcohol is the most popular, it is also interesting to note that twice as many people become dependent on alcohol, as compared to all other drugs combined, to bring this into perspective it is estimated that 1 in 12 of our population has a serious alcohol problem(4). If we add to that the fact that 1 in 20 of our population, presents with depression (5), the link between the two becomes apparent, leading to a condition sometimes referred to as dual diagnosis, however that description is only accurate if two disorders are present I.E. substance abuse and depression, since most heavy users also experience other psychiatric symptoms, their condition is more accurately referred to as comorbidity.

Many people argue that it is stress, anxiety, or depression that leads to people to misusing AOD, perpetuating the myth that by removing those factors normal consumption is restored; this is a popular hypothesis used by 'social learning theorists; however the Royal College of Psychiatrists (RCP) take an entirely different view, and that it is the reverse that is true. Further research carried out by the Royal Edinburgh Hospital, concluded: '*There is sufficient evidence to suggest that a diagnosis of depression currently presenting, may change to one of alcohol dependence alone, The prognosis for those who continue to remain depressed remains unclear'*(6). There is so much evidence linking alcohol abuse with stress, anxiety and depression (SAD), that one could write a number of articles, without repeating the same references; that they are inextricably linked is almost universally accepted, further the general consensus of opinion, is that treating either condition without addressing the others is likely to be ineffective, given that many of the conditions we are presented with indicates SAD, we should at least be aware if alcohol abuse is present. Unfortunately those who are abusing alcohol tend to be less than truthful about their consumption, therefore simply asking them how much they drink, is unlikely to elicit the truth, therefore, if we are to have a clear picture of cause and effect, knowledge of how to screen for the presence of abuse is essential, the questions in the following table are based on DSM-1V criteria:

Table: 2

How often during the last year have you missed school or work because of the effects of alcohol?	
Are you spending less time with your family as the result of using alcohol?	
How often in the last year have you been in physical danger as the result of using alcohol?	
Has your relationship with friends, and/or other family members been affected by your use of alcohol?	

If any *one* answer produces an affirmative, it is defined as substance abuse; however, if two or more responses are positive, the questions in the following table should be asked:

Table 3

How often in the past 12 months have you felt unable to stop drinking once you had started?	

How often in the past 12 months have you experienced sweating or rapid heartbeat?	
How frequently do you find a marked tremor in your hands?	
How often in the past 12 months have you felt nauseous or vomited after drinking?	
How often in the past 12 months, have you experienced hearing unexplained noises, or thought you had seen something that was not present?	
How often during the past 12 months have you felt more anxious than normal?	
How often during the last 12 months have you experienced difficulty in sleeping?	

If there is an affirmative to two or more in table 3 combined with two or more in table 2, then in the absence of any other medical reasons, we are now looking at dependency, but don't expect your client to agree. Addiction, especially alcoholism is often described as the 'disease of denial'; after all who wants to admit, or accept that they are bodily, or mentally different from their fellow man? At this stage, unless my client is presenting with alcohol related difficulties, I ask a seemingly innocuous question; *do you think you drink because of your problems, or do you think alcohol is the cause of your difficulties?* Whatever the answer, I now know how to proceed.

I hope it will be seen from the foregoing that it is not the quantity or type of alcohol that is consumed, but rather its effect on an individual; the so called safe drinking levels stipulated by the government, 14 units per week for women and 21 for men is purely arbitrary, it has never been agreed by the British Medical Association or the RCP; further it is flawed insofar that those quantities were established when imperial measures applied, today all measures are in metric which are larger than the old imperial unit.

Having established the presence of abuse or dependency, what to do? Unless you are qualified to the minimum standard of the Drug and Alcohol National Occupation Standards (DANOS), and registered accordingly, it would both be in your own and your client's interest to refer him to the local community Drug and Alcohol Action Team (DAAT), which you should find in yellow pages, or under your social services mental health team listing. It should also be noted that this is one area of counselling and/or psychotherapy that is strictly regulated by the government, and the Advertising Standards Authority has proscribed advertisements, offering assistance with substance misuse or dependency unless evidence of qualifications are offered; equally

qualifications from training organisations that are not DANOS approved are unacceptable. However this does not necessarily lose you a client, you can point out to him that his interests would be better served by attending the above, which can be by way of self referral or through his GP, in the interim you can still address his SAD issues, however as I said earlier unless his drinking is addressed in parallel, relapse in any of his conditions is more likely than not.

In part two, we will look at the criteria for establishing the presence of cocaine, heroin, and cannabis, together with the universal 'gold standard' frame work that those who are qualified
in addictive behaviours work within, together with the evidence based, models of psychotherapy used.

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