

TOWARDS A RATIONAL APPROACH TO SUBSTANCE USE BEHAVIOUR

The management of substance use behaviour is always a daunting challenge for the medical practitioner, as there are a number of factors that complicate the problem.



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Firstly, drug use is always seen and understood through a socio-political perspective which can be fickle and often dependent on the prevailing political climate. Secondly, there is no universally accepted consensus about drug use behaviour among the authorities and experts despite the ubiquitous nature of the problem. Thirdly, the very act of substance use in most jurisdictions is a criminal behaviour which makes unfettered assessment difficult and finally, much stigma still surrounds drug use, which prejudices the observer trying to assess the problem.

Broadly speaking, 3 groups of people use mood-altering chemicals and the management of each group is quite different. Effective and credible management of substance use behaviours requires an understanding of the differences between each group and an ability to triage the patient accurately (Fig. 1).

	PATTERN OF USE		MANAGEMENT
70%	SOCIAL OR RECREATIONAL DRUGS USE	USE IS A CHOICE	REQUIRE INFORMATION AND EDUCATION
20%	ALCOHOL OR DRUG ABUSE	USE IS A SYMPTOM	RESPOND TO 'BRIEF INTERVENTIONS'
10%	ALCOHOL OR DRUG DEPENDENCE	USE IS AN ILLNESS	USUALLY REQUIRE TREATMENT

Fig. 1. Classification of people who use mood-altering chemicals.

SOCIAL USE

The first group of people who use substances, and by far the largest group, are recreational or social users, now often described as non-dependent users. The drug use in this group is usually around a recreational activity and is conducted with friends. It causes no problems for the user or his/her family and there is no guilt about the behaviour. This group by and large use chemicals with no significant psychosocial dysfunction or impairment. The mood-altering quality of the drugs provides some form of relief for the user and the drug use activity is a choice with no sinister consequence.

It goes without saying that, even though social use may be a choice for these people, it will not protect them from the intrinsic dangers of intoxication or the hazards of ingesting non-pharmaceutically prepared chemicals. The dreaded 'gateway effect', namely that early drug use results in addiction, is simply unproven. Only the triad of alcohol, drugs and nicotine together has been predictive of substance dependence disorders. Most people start drug use under very innocent circumstances in a non-hostile environment and that is the way it remains. The intervention required by these patients is accurate information and

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education around drug use, so that they can make sensible and responsible decisions, should they choose to use drugs. The vast majority of drink-drive campaigns, schools drug education programmes and media drives are targeted at this group, and although they are the largest group of substance users, they cause the least amount of problems.

With respect to this group, the majority of whom are upright law-abiding citizens, their decision to use illicit chemicals supercedes the implicit moral and legal issues surrounding the use.

SUBSTANCE ABUSERS

The next group of drug users, estimated to be approximately 20% of the

total, are the substance abusers. For this group, the drug use is usually symptomatic of underlying and unresolved problems, usually of a psychosocial nature, e.g. marital or relationship difficulties, financial problems, childhood problems, dysfunctional family problems. If one can identify and address the underlying problems effectively, the substance use will approximate to an acceptable level or disappear completely in most of these patients. These patients require referral to the appropriate agency, often a counselling psychologist, psychiatrist, accountant, personal trainer or divorce lawyer. Many, however, will respond within the doctor's consulting room to the 'brief intervention',¹ a structured and customised technique of dealing with substance abuse.

Distinguishing between substance abusers and substance dependents can be a very close call. At the initial consultation, when dependence is not clearly evident, it is advisable to err on the side of substance abuse with respect to diagnosis and management, giving the patient the benefit of the doubt. This always serves to strengthen the therapeutic alliance and keep the door open, should further problems arise. In most communities where drug use is rife, it is usually this drug abusing component of the overall using population that grows in response either to conditions of social deprivation or indulgence (see Table I for the *DSM IV* criteria for substance abuse).

SUBSTANCE DEPENDENT

The third, smallest, but clinically most important group of substance users are those whom we regard as substance dependent. The lifetime prevalence of

this condition remains remarkably constant irrespective of sociopolitical conditions or environmental circumstances and stands at approximately 13.5% for alcohol and 6.1% for other mood-altering substances, excluding nicotine. Although this group constitutes approximately 10% of substance users, they probably cause 90% of the problems. They are the addicts and alcoholics. The clinical challenge is to identify this group among all those presenting with signs suggestive of drug use behaviour. They are regarded as 'certainly ill'² with an involuntary and compulsive condition that, if untreated, inevitably leads to serious harm. A suitable treatment intervention is the most effective means of addressing the problem for these people.

The fundamental pattern that describes substance dependence is typically one of drug use, adverse consequences and then repetition of using. In reality, this translates into impaired control over the consumption of mood-altering chemicals, despite the negative consequences – this is the hallmark of an addictive disorder. Unfortunately, a precise definition of this loss of control eludes the authorities in the field and so the diagnosis of substance dependence ultimately rests on a subjective assessment of a set of data that are very often further distorted by an intricate denial system. The denial system, which is very characteristic of all addictive disorders, is a personalised subconscious defence mechanism composed of faulty cognitions and distorted beliefs designed to protect the addict from the very thing they fear the most – their addiction.

Unfortunately the notion of loss of control is not purely about the quantity of drug use, that is, how much or how often, but more accurately characteris-

Table I. **DSM IV CRITERIA FOR SUBSTANCE ABUSE**

- Recurrent substance use resulting in failure to fulfil major role obligations at work, school or home
- Recurrent use in physically hazardous situations
- Recurrent substance-related legal problems
- Continued use despite social or interpersonal problems caused by the use

Table II. **DSM IV CRITERIA FOR SUBSTANCE DEPENDENCE**

- Persistent desire or unsuccessful efforts to cut down or control use
- A great deal of time is spent in activities necessary to obtain, use or recover from the chemical use
- Chemical is taken in larger amounts or over longer periods of time
- Important social, occupational or recreational activities are given up or reduced because of the chemical use
- Chemical use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by it
- Tolerance
- Withdrawal or use to avoid withdrawal symptoms

es the relationship with drug consumption. *DSM IV* diagnostic criteria (Table II) for substance dependence essentially look at loss of control with respect to 5 different parameters, while criteria 6 and 7, namely tolerance and dependence, suggest that the condition has become chronic.

The diagnosis of addiction is further complicated by 2 factors. All addicts enter the system initially indistinguishable from recreational users, pass through the abuse phase and then land up as established drug dependents. This makes identification in the early stages extremely difficult and yet early diagnosis, as with all malignant conditions, would vastly improve the prognosis. In this way, addiction sustains itself in that as the condition deteriorates, the less is the incentive to address the problem. The process becomes a self-sustaining ecosystem in that the addict is eventually using drugs to deal with the pain caused largely by the drug use. In contrast, early interventions are equally difficult because the consequences are usually not severe enough to motivate for treatment and the addict remains in a delusional state of well-being.

It may also be extremely difficult to tease out an addiction where there is iatrogenic physiological substance dependence arising from the dependence-producing pharmacological properties of certain chemicals. Very often, the most difficult clinical scenario is the detection of an addiction where there is a proven underlying organic disorder that warrants mood-altering drugs as the first-line medication.

ORIGINS OF LOSS OF CONTROL

A further unanswered controversy in the field of addictive disorders is the aetiology of the condition, or more specifically the origin of the loss of control. Pure disease model theorists would see loss of control as a manifestation of a neurobiological dysfunction, possibly in the reward system of the midbrain or of the inhibitory systems of the frontal cortex. The condition occurs in pre-determined genetically vulnerable subjects and there are very good adoption and twin studies to support this idea.³ Behavioural scientists would see the problem of addiction as a function of multiple psychosocial variables or a dysfunctional response to adverse circumstances. There are those (on the extreme right!) who believe that the addiction, as a distinct diagnosable entity, doesn't exist at all. In truth, we are a long way off from identifying the precise aetiology of addictive disorders.

TREATING ADDICTION

The treatment of addiction is undermined by 3 myths. The first erroneous belief is that nothing works. Addicts never get better despite the treatment interventions. This perspective reflects an ignorance about the malignant nature of the condition and that it has an extremely guarded prognosis. However, most addicts function much better after treatment than prior to treatment, although not all remain absolutely abstinent. In fact, there are 2 very distinct treatment camps, those who view abstinence as the only

acceptable treatment objective and those for whom non-hazardous controlled use would be acceptable. About 30 - 50% of treated addicts are in a state of stable and sustainable sobriety at the 5-year mark.

The second myth is that everything works. In other words, addicts get better when they, themselves, decide to address the problem. Until that elusive point is reached all interventions are futile, and after that point the nature of the intervention is immaterial as anything will work. This view reflects an ignorance about the nature of addiction treatment, which is largely designed to bring about a sustainable commitment to abstinence. Fundamentally, addiction treatment is about effecting a behaviour change and the stages of change model is particularly useful in understanding this process. The act of not using drugs is in and of itself not particularly complicated. The challenge of successful treatment is to restructure the distorted cognitions and dysfunctional beliefs that sustain the addiction and then to try and build in safety mechanisms.

The third myth is that there is a single outstanding effective approach that is superior to the rest. The reality is that the treatment outcomes for most psychosocial interventions are strikingly similar. Unlike the removal of an appendix, where there is more or less agreement on the best way to go about the procedure, there is no universally accepted successful method of treating addiction.

The treatment of addiction occurs in 3 phases – detox, treatment programmes and continuing care. Detox is the most feared by many addicts, who have often tried to achieve this on their own, and yet it is the least complicated part of the process. A well-managed medical withdrawal procedure should be largely uneventful. The danger is that many addicts confuse the detox with treatment and this results in repeated unnecessary readmissions. The other controversy concerns self-administered outpatient detoxes where the doctor prescribes a bottle of methadone or some diazepam. These are rarely successful and often simply introduce a sense of hopelessness into the situation.

Treatment programmes vary from residential 21-day programmes to long-term incarcerations. Longer treatment has not been shown to produce better outcomes and I believe the best length of treatment is about 90 days, not all of which needs to be residential. In addition, outpatient programmes, one-

to-one counselling services or the mutual help fellowships are all effective and matching the patient with the intervention is critical. Coercing a patient into an inappropriate programme raises resistance and results in treatment non-compliance.

Continuing care follows the primary programme and may be in a contained environment like a step-down facility, a clinic-related aftercare programme or Alcoholics Anonymous. If addiction is viewed as a chronic condition, then continuing care is a critical part of the process of recovery. Early relapse invariably occurs when patients neglect continuing care support. The recovery process loses momentum when addict and care-giver alike view relapse as treatment failure. Relapse, if well managed, can be a pivotal event in the recovery process.

Not all drug use is drug addiction. In many instances, an addiction will reveal itself and is then best managed by specialists. The skill for the general

practitioner is the detection of those cases camouflaged behind other clinical problems and then managing the patient towards the most appropriate treatment intervention, as determined by an accurate diagnosis.

References available on request.

IN A NUTSHELL

Not all drug use is drug addiction.

Drug use may be a choice, a symptom or an illness and the management differs for each group.

Addiction is about a specific type of relationship with drug use identified by a loss of control over the use.

Treatment of addiction is hindered by much mythology.

Detox should never be confused with drug addiction treatment.