Publication: CapeArgusEarly (Weather)
Publication Date: 06 Sep 2017
Page: 10

AVE: 67681.15
Circulation: 29707
Part: 1 of 1

Changing attitudes on addiction

Quitting drug use and maintaining sobriety requires knowledge, skill and determination

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"IT'S better if an addict dies – that way family members endure less suffering over a shorter period of time." That was the gist of my very first lecture on drug addiction during my childhood. It was said with such conviction that I have to admit it stuck with me for a number of years.

"It's only by the grace of God that I'm not an addict today. I don't seem to have a genetic predisposition, I was not exposed to substances during my adolescent years, I was not neglected or abused as a child and I grew up in an environment where drugs were neither accessible nor acceptable."

My supervisor said this to me on the first day of my addiction rotation as a doctor specialising in psychiatry. Over the past few years I've had the privilege of hearing first hand the accounts of individuals struggling with a chronic addiction, what had led them to this point, and I've witnessed the courage and determination that is required to change that path.

The risk of developing a chronic addiction is not shared equally among ourselves. The same could be said for other chronic conditions.

Our risk of developing disorders such as asthma, diabetes and hypertension will depend on our genetic susceptibility, our exposure to risk factors and the role our environment plays in facilitating the development of these disorders.

While we have criteria to diagnose an addiction, diabetes and hypertension, we are still not capable of predicting which individuals will develop these disorders.

Addiction differs from other chronic medical disorders in many ways, the most obvious being that intention and insight was present during initiation, during every episode of using a substance and with every relapse. So why then should this be considered a chronic medical disorder?

Substance initiation often occurs during adolescence. Physical changes associated with puberty, the emotional shifts, social transitions and increased risky behaviours make this a particularly vulnerable period. Research has shown that our brain development continues to occur until our early twenties.

Our ability to screen our environment, assess options and weigh up consequences associated with our decisions are not fully developed during this period of neurodevelopment. Teenagers are therefore still in the process of developing their capacity to make the best possible decision in the environment they find themselves in.

While peer pressure has been found to be the most common cause for substance initiation, it is the subjective benefit obtained from the substance that is most likely associated with continued use.

HABIT: 'Chasing the dragon' is a form of smoking heroin, a highly-addictive drug. PICTURE: NEIL BAYNES

> "'MEDICAL MODEL' OF ADDICTION DOES NOT MEAN TO STIGMATISE AN INDIVIDUAL AS HAVING ANOTHER 'CHRONIC DISEASE', NOR USED TO JUSTIFY ONGOING DRUG USE

Our genetic profile has the ability to determine the way we experience various substances. Some may find the experience of intoxication as being highly rewarding while others may experience it in a negative manner.

For many individuals substance intoxication offers more than just euphoria or reward though, it also offers an escape from a tumultuous internal environment.

The environment we find ourselves in and the way we perceive that environment are two other critical risk factors towards the development of an addiction.

Edward Khantzian, the originator of the self-medication hypothesis of drug abuse, hypothesised that an individual's drug of choice was based on their form of distress or suffering, that it was used as a means of self-medicating that distress.

The National Youth Risk Behaviour Survey conducted during 2011 surveyed 10 997 pupils in grades 8 to 11 across South Africa. This study found that 7% of pupils reported carrying weapons on school property, 21% felt unsafe at school during the past month and 12% were threatened or injured by someone with a weapon while on school grounds.

In the six months preceding the survey, 25% of pupils reported having experienced feelings of sadness or hopelessness, 18% had considered suicide and 18 had attempted suicide. In terms of alcohol use, 49% reported ever having drunk alcohol and 25% having engaged in binge drinking. These statistics offer only a glimpse of the difficulties our youth struggles with today.

Addiction therefore often begins by means of vulnerable individuals finding themselves exposed to substances, often starting in their youth, and experiencing a relief from their internal or external environment. With repeated exposure these individuals are likely to experience brain changes that facilitates the feeling of reward obtained from drugs, decrease the sensation of reward obtained from other means, requiring larger quantities to maintain that sensation and experiencing difficult withdrawal symptoms when attempting to cut down. These brain changes have also explained why environmental cues are able to induce strong cravings for further use and why individuals struggling with an addiction are prone to impulsive actions when craving drug use.

This "medical model" of addiction does not mean to stigmatise an individual as having another "chronic disease", nor used to justify ongoing drug use.

It does, however, provide us with insight into current evidence within this growing field, it acknowledges that these were once highly vulnerable individuals, and that the act of maintaining sobriety requires so much more than just "a decision to stop using", sobriety requires knowledge and skills.

These "skills" requires input and guidance from trained professionals that are capable of offering evidence-based treatment.

This model highlights the importance for ongoing protection and care of our young children and adolescents. This period of development provides caregivers the opportunity to instil resilience and an ability to manage internal conflict. Without this emotional buffer, adolescents may resort to other means of managing distress.

The medical model provides us with one further insight. Like other chronic disorders that require regular reviews, assessments and adjustments to treatment, those who have struggled with a chronic addiction should allow for regular "check-ins" as well.

After-care groups offer a means for ongoing support and should be capable of highlighting any changes in behaviour that warrants more urgent intervention.

Many seem to be under the impression that individuals should be "cured" after an admission to a drug rehabilitation unit, that any relapse after such a process indicates a failure or weakness, not acknowledging our incorrect assumption that a chronic disease can be cured by means of an acute, short-term treatment.

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