

SOME THOUGHTS ON ADDICTIVE DISEASE

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Politically I am a Libertarian. I don't like governments. They are domineering and expensive and frequently counter-productive. Whatever their good intentions, they tend to achieve the opposite. They get in the way of imagination, enterprise and individualism. They promote a culture based upon influence and graft rather than achievement. An all-powerful Civil Service takes to itself the implementation of the laws of parliament, as it is required to do, and the population, from front line worker to board room director, have to do as we are told. It is arguable that the army and the police force need this level of centralised management but there are some who believe that even these sectors of our society should be privatised. I myself believe that health and welfare and education are of such importance that they are the very last subjects, rather than the first, that should be trusted to government control.

I hope that this introduction establishes my Libertarian credentials. At one time, I was on the board of the Libertarian Alliance but left (amicably) on the issue of whether or not the use of addictive substances and processes is a lifestyle choice or, in some people, an illness.

There is a danger in believing that experience brings knowledge. However, there is also the opposite danger in believing that one has knowledge when one has no experience. I myself am an addict and over the last twenty years I have treated over four thousand addicts on an inpatient basis. On the subject of addiction I have both knowledge and experience. None the less I recognise the obvious challenge to my belief that addiction is a disease: well you would believe that wouldn't you? This may imply that I believe that saying addiction is a disease absolves me and others like me from responsibility for our behaviour. I do not believe that at all. I believe the opposite: awareness that one has an illness should give one a sense of responsibility not to exacerbate it and thereby harm oneself or other people.

To use a simple analogy, I acknowledge that, relative to most other people, I am short-sighted. I therefore accept the responsibility of wearing glasses. I am short-sighted whether I wear them or not: they do

not cure me of a disease that is genetically inherited. I wear glasses in order to be functional, in order to read books and drive my car. If I fail to take the responsibility of wearing my glasses when driving my car, declaring that it is my free choice not to do so, and then cause an accident that injures myself and other people, I believe that I would be culpable. I would not be responsible for being short-sighted in the first place but I would be responsible for the damage that I cause through my arrogance and self-will.

In the course of my work with addicts of all kinds I have come to believe that the tendency towards addiction is a genetically inherited disease mediated through a chemical defect in the neuro-transmission systems in the mood centres of the brain. Indeed, considering the complexity of brain biochemistry, it would be absolutely incredible if there were not genetic defects associated with this function: nobody questions that my short-sight has a genetic origin yet optics are a much less complex function than neuro-transmission. Nobody questions that Downs Syndrome is a genetically inherited disorder of intelligence. There should equally be no surprise in considering that sometimes the emotional functions of the brain could also be genetically impaired.

The problem with accepting that an addictive tendency is a disease comes as a result of two attitudes. Firstly, people tend to have a fairly narrow sense of what constitutes a disease. Infections, cancers and deteriorations such as heart attacks are all generally accepted as diseases. But what about congenital defects on the effects of old age and the results of sports injuries? Nobody would question that these are worthy subjects for the attention of doctors but that doesn't necessarily make them into diseases in a narrow sense. Similarly, doctors deal with the consequences of bereavement, unemployment, marital break-up and many other emotional traumas. These might be called dis-ease but not disease.

Contraception would be considered to be a personal responsibility and certainly not a disease yet doctors have no second thoughts about providing it. In other words, the concept of a disease cannot be defined by whether or not a doctor is prepared to

spend time on it. Interestingly, however, many doctors reject addicts precisely upon the grounds that they consider their problems to be self-induced, a personal responsibility, merely an emotional problem or a social rather than clinical problem. They don't mind dealing with the physical consequences but they do not see that dealing with addiction itself is a medical responsibility. This can lead them to be very angry when the term 'addictive disease' is applied to addicts because they feel that clinical practice is being usurped by people and conditions that do not deserve to appropriate the word 'disease'. Secondly, people, including doctors, wonder what sort of a disease addiction might be. They can see the consequences of addiction—medical, financial, social, educational, marital, emotional and all the rest—but they still find it difficult to call the origin of all these problems a disease. As with seeing the carnage caused by an elephant, they may not see the elephant (or disease) but they can see where it has been. Often the people who most resent addiction being called a disease are those who have been damaged by addiction in someone else in their family or work place. They are happy to be sympathetic towards people with cancer or heart attacks but may be very resentful towards the person who caused them so much pain and resentment if he or she could hide behind the concept of having a disease.

A further difficulty comes from trying to distinguish addicts from non-addicts. Many people drink alcohol but that doesn't make them alcoholics. Alcohol is an addictive substance but different people react to it in different ways. Correspondingly, some cigarette smokers are able to give up when they put their minds to it but others find themselves repeatedly drawn back to it. As Mark Twain said, 'giving up smoking is easy—I've done it nineteen times'. People who become significantly obese do not appear to have a stop button in their relationship with sugar and white flour, the substances that cause craving for more and more. Compulsive gamblers, workaholics, shopaholics, exercise addicts and sex and love addicts have behavioural addictions that are just as destructive as many substance addictions such as alcoholism or drug addiction, yet they are resented and mocked if they ever refer to themselves as addicts. Again, it is assumed that they are weak-willed or stupid or that they are making excuses for personal inadequacies. Yet studying these people does not reveal them to be weak-willed at all. Often they are far too strong-willed—interminably trying to prove that they can manage something sensibly when all the evidence of experience says they cannot.

At PROMIS we find that addictive tendencies tend to go in clusters. First there is what we call a hedonistic cluster (alcohol, recreational drugs, prescription drugs, nicotine, caffeine, sex and love addiction, gambling and risk taking), second there is what we call a nurturant of self cluster (food-bingeing, vomiting, starving, purging-exercise, work, shopping and spending) and the relationship cluster (using other people as if they were drugs or using themselves as a drug for other people). Some of our patients have all their addictive tendencies channelled into just one of these clusters, some have two and some have all three. Our belief therefore is that each of these clusters may be mediated by one gene. It is no surprise to me that a gene for alcoholism has not been discovered. I cannot see the evolutionary benefit in having such a gene. However, I can see the evolutionary benefit of a hedonistic gene. Hedonists maybe highly energetic and creative and give something to society but then destroy themselves in the process. Similarly I can see the evolutionary advantage of a nurturant of self gene or a relationship gene. Each of these has potential benefits to society even while forcing the individual to fall apart at the seams.

Paradoxically, people with addictive behaviour of one kind or another very commonly believe that they are expressing their right to individual freedom of choice. In fact, as addiction takes hold, they achieve the exact opposite: entrapment. Furthermore, they become indistinguishable from other addicts. By trying to be individualistic, they become standardised. When you have seen one alcoholic or drug addict or anorexic, you've seen them all—not as individuals but as representatives of their addictive group. The tragedy is that the individual characteristics of addicts that distinguish them from each other become progressively less apparent. As the consequences of their addictive behaviour and the progressive losses mount up, they lose all their individuality.

A further reluctance to allow the term 'disease' to be applied to addiction is that it is assumed (just say no) that treatment is in the sole hands of the sufferer and there is nothing anybody else can do. This is true, as countless doctors, social workers, probation officers, health visitors and Uncle Tom Cobbley can testify. Many a professional has been brought to tears by recognising that his or her sincere intentions and best efforts have come to nothing in trying to help addicts. They have a self-destruct process that does not respond to reason, nor to encouragement. Any material support is taken for granted or squandered. Addicts with perfectly good brains—as seen

in their professional work and other aspects of their lives turn them off when they have an opportunity to use an addictive substance or process. The understanding of this feature of addiction is crucial: addicts do not have a disease of their intellect; they have a disease of their feelings. Samaritans estimate that 30% of all suicides are in alcoholics alone.

Other estimates are that 95% of all suicides are in addicts of one kind or another. This seems bizarre when the people who kill themselves have often had significant privilege, a great deal of love and support and many opportunities to make use of their intellectual and practical skills. Still, they have a dreadful sense of inner emptiness, an involitional melancholia which bears no relationship whatever to their personal circumstances. It is small wonder that their lives are irrevocably changed when they are introduced to mood-altering substances or processes. Suddenly life is bearable, manageable. Why ever would they want to give up these substances and processes that provide such solace? The sad fact is that most of them don't: they die. In the UK, three hundred nicotine addicts die every day, one hundred alcoholics die each day and fifteen drug addicts die each day. Estimates for the number of people killed by sugar and white flour are difficult to determine but two hundred deaths a day seems likely.

Addicts have to be distinguished from idiots. Lots of people get drunk or take cannabis or have a pork-out but this doesn't make them addicts. If we sweep the streets for people who are drunk late at night, many will turn out to be students, doing what students do. Some of those students will be alcoholics but it is very difficult to make that diagnosis at the time when they are horizontal alongside their peers. The Shorter PROMIS Questionnaires (www.promis.co.uk) are based upon addictive characteristics that are quite separate from social factors. All the questions are based upon one principle: why? None of them relate to how much? , when? , which type? or other questions like that. For addicts there is only one goal: alteration of mood. Other people may have a bit of fun, do a bit of retail therapy, get slaughtered once in a while, or whatever, but for addicts the basic purpose of mood-alteration is to lift the black dog of depression and stay alive.

In fact I believe that depression and addiction are synonymous, the same condition before and after treatment with a mood altering substance or process. Sadness is something altogether different: the normal human response to an unfortunate circum-

stance. Sadness should be treated with understanding and support and time. It resolves on its own. Depression/addiction should never be treated with antidepressants because these are addictive substances in their own right in people who have addictive tendencies. The correct treatment is the Twelve Step programme, first formulated by Alcoholics Anonymous. Ultimately the substitute mood-altering process that works for addicts is when they take the focus of their attention off themselves and put it onto other addicts. When A reaches out to help B, it is A who gets better. The process wears off (just as drunkenness wears off if one stops drinking) and therefore one has to repeat the process which is the precise purpose of attending regular meetings of Alcoholics Anonymous and reaching out to help newcomers. Nowadays there are a whole range of Anonymous Fellowships covering a whole range of addictive substances and behaviours. At times, the range is too broad and people who are not addicts at all try, for some bizarre reason best known to themselves, to try to prove that they are. Presumably they want to avoid taking responsibility for themselves. Recovering addicts (those who work a Twelve Step programme on a continuing daily basis) do not at all want to avoid responsibility. They accept it with open arms. They acknowledge their addiction (just as some of us have no choice but to acknowledge our short sight) and they do what they can on a continuing basis to keep it at bay so that they do not get the long term consequences for themselves or inflict them upon other people.

Thus, addictive disease in my view has both a cause and a treatment. Open meetings of Alcoholics Anonymous and other Anonymous Fellowships exist in order to increase understanding in those who may not be addicts themselves but who genuinely want to develop an understanding of addictive behaviour and see what can be done about it. There are now 2,400 groups of Alcoholics Anonymous meeting each week in the UK. Yet the basic ideas of a Twelve Step programme are not taught in British medical schools, nor are there any Minnesota Method treatment centres (based upon the principles of the Twelve Step programme) in the NHS. It is small wonder that doctors and other healthcare professionals resent the word disease being applied to addictive behaviour. They know nothing about it.