Pacific Views

Newsletter for Healthcare Professionals

Autumn 2014

SOUTH PACIFIC PRIVATE
Australia's Leading Treatment Centre

What is this thing called Addiction?

Professor John B. Saunders, South Pacific Private

Professor Saunders is a consultant physician and advisor on addiction medicine at South Pacific Private, and has appointments at Sydney Medical School, University of Sydney, and in the Faculty of Medicine and Biomedical Sciences, University of Queensland. Professor Saunders has been a clinician, researcher, teacher and director of addiction services for 40 years.

Ask a politician what addiction is and you will likely have a response that includes the term *"self-inflicted problem"*. Ask a member of the general community what addiction is and you may hear remarks about people taking drugs for the sake of it. Ask a health professional about addiction and you are likely to have a variety of responses. You may be greeted with *"Oh I don't deal with those sort of problems"*. You may receive an elegant discourse on social learning theory or a sociological explanation on power relations in society, or it may be explained that substance use is a consequence of a mental health disorder.

Confused? You might well be. Historically there has been immense confusion as to what addictive disorders are, with many conflicting views, proposed explanations, and philosophies.

One should not criticise members of the community, various health professionals or even politicians for these immensely varied interpretations. In reality, the nature of addiction has been explored from many different professional and scientific standpoints, and there is a lot of truth in explanations that come from social learning theory, social science, psychiatry, and epidemiology. However, what has been lacking is a coherent synthesis of what we know about these disorders and that people with the disorders experience.

What, therefore, is this thing called "Addiction"?

At one level addiction is simple to understand. It starts, necessarily, with the repeated use of a substance which has particular effects on the brain and mind. Some of the substances are naturally occurring or, like alcohol, are produced through natural processes such as fermentation of grapes or cereals. Some are pharmaceutical substances or otherwise chemically manufactured. A more modern form of addiction is that due to a repetitive activity such as gambling or gaming, but this article will focus on addictions due to substances.

continued...

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Social influences

Substance use is rarely, at first, a solitary activity. In all human societies, alcohol consumption (for example) is most likely to occur in a group setting, particularly amongst friends and peers. There are, therefore, important social and cultural influences on the uptake of a particular substance - be it alcohol, tobacco, marijuana, Ecstasy tablets, coca leaf or betel nut. Someone once remarked that if a society was discovered where alcohol consumption occurred primarily in isolation or with companions who were much older or much younger than you, that it occurred more frequently in the elderly than the young, and in women much more than men, then those people would be radically different from any human society hitherto known.

Behavioural influences

The field of behavioural psychology has contributed a lot to our understanding of how repetitive patterns of substance use can develop. In particular, people learn the effects of the substance in certain settings and the perceived advantages and disadvantages. The most widely accepted theory is social learning theory which states that a repetitive behaviour such as drinking occurs through the person observing or experiencing a behaviour and its positives and negatives, that it is a cognitive process, and that it is influenced by the personal and social environment. Positive observations and experiences are likely to encourage consumption, negative and adverse ones will likely discourage further use or use beyond certain limits.

But there is more

These explanations contribute to our understanding of how repetitive substance use can start and become a pattern or habit. However, addiction is so much more than this. In addiction, the use of a particular substance increasingly occupies centre stage in that person's life. It continues even despite harmful consequences, whereas sociological and behavioural psychology explanations would suggest that substance use would be sensitive to harmful consequences and would be reined-in at that point.

With addiction this does not happen. Indeed, one of the central features of what is termed substance dependence (essentially synonymous with addiction) in the International Classification of Diseases, 10th Revision (ICD 10), is *"continued use despite harmful consequences".* How can loss of control over substance use or the presence of withdrawal symptoms have explanations in social science or psychological ways? People with addictive disorders increasingly experience feelings about alcohol or drugs that seem beyond these explanations. The sense of increasing loss of control, the sense that life is moving in a direction that they seem to have little influence over, the disturbing experiences due to using too much or the after-effects such as the emergence of withdrawal symptoms suggest that something far more powerful is developing inside them.

The brain changes

This is where our developing knowledge of the neurobiology of addiction helps so much. Research largely undertaken over the past 20 years has identified key circuits in the brain that are responsible for the increasingly powerful grip addiction has on an individual, and the transition from substance use which is largely under a person's control to the stage where it clearly is not. The neurocircuits that are the anatomical location of addiction are located in the basal ganglia, the ventral tegmental area of the mid-brain and the lower forebrain. There are four key neurocircuits which in response to repeated use of a substance become physiologically altered or "re-set" in an enduring way.

These include:

1. **The reward circuitry**
   The reward circuitry is responsible for the initial effect of a psychoactive substance, which in many, indeed most cases, is regarded as pleasurable. With increasing use of the substance the reward circuitry becomes blunted. The effect is less pleasurable, more substance is required to obtain the desired effect. The reward circuitry becomes progressively "hijacked" by use of that substance, with the result that other enjoyments (food, love, sport, sex) become blunted and dull. The person descends into a state of depression and lack of motivation.

2. **The alertness system**
   The brain has a centrally important system governing alertness or somnolence. This is a crucial survival mechanism, given that a degree of alertness is vital to ward against danger. Many substances suppress alertness (alcohol for example) and repetitive substance use will cause adaptive changes in these pathways resulting in a heightened state of arousal or excitation. This helps explain the common feelings of hyper-arousal and anxiety that occur in persons with addiction. It provides a ready explanation as to how people with addictive disorders are triggered by the site, smell or taste of their preferred substance and can be triggered also by environments associated with alcohol consumption (for example) or groups of friends or environments such as a pub or club, or even unpleasant internal feelings.

3. **Prioritisation**
   Salience or prioritisation circuits in the brain determine thoughts and behaviours in relation to their comparative importance for the individual. Normally, obtaining and eating food, and self-protection would be accorded high priority by a person. As addiction develops, priorities change and can do so fundamentally. Changes in the salience neurocircuitry result in substance use and activities associated with it being accorded a much greater priority by the individual. Activities that once had high priority become relegated to the periphery.

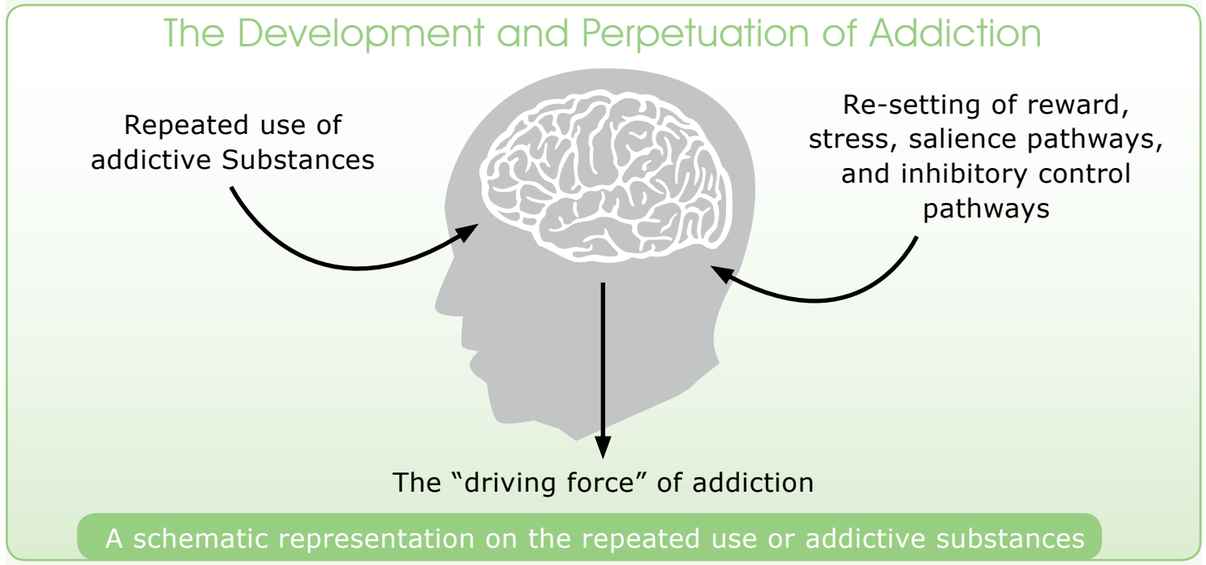
FEATURE ARTICLE

Accordingly, substance use occupies more and more of the person's daily life and important daily activities such as work, study, family responsibilities and even personal care drop in order of importance.

4. **Behavioural control**
   A modest degree of behavioural control normally exists to influence urges to drink alcohol or take other substances. This affects whether a particular substance is used or not, how much is used and in what particular circumstances, and to determine when substance use should cease, thus allowing the person to return to their normal (non-using) state. With the development of addiction, there is progressive impairment of these behavioural control pathways such that primitive responses described above which produce urges and loss of control over substance use, have no brake

Neurobiological changes explain how addictive disorders develop from patterns and habits of use to powerful internal drives that become less and less responsive to attempts at voluntary control. There is a sense of substance use escaping the ability of the person to regulate it. Instead, it reflects an unthinking primitive neurobiological drive.

From this recently acquired scientific knowledge, we can now interpret addictions as the serious disorders they are. Modern scientific understanding is increasingly in accord with what those with addictive disorders actually experience. It is curious that it has taken a hundred years of scientific endeavour to bring professional views more in alignment with those of people who have actually experienced addiction for themselves and know powerful and destructive a disorder it can be.



A schematic representation on the repeated use or addictive substances

put on them. Substance use therefore tends to continue until no more is left or the person becomes stuporous or is told by a partner or elder to stop. Even in the latter situation impairment of behavioural control can result in such a request being ignored.

Addiction, therefore, is a human disorder that arises from neurobiological changes that result in repetitive substance use escaping the control of the individual and becoming a potentially all-consuming activity. This is not willed by the individual: *hence our politician is fundamentally wrong in concluding that addictive disorders are primarily self-inflicted problems.* The addictive process means that substance use escapes from the normal control of the individual and is little influenced by that person's responsibilities in life and the expectations of other people.

As an important mentor in my professional life, Professor Griffith Edwards, said to me, **"Never underestimate addiction".**

About Professor John Saunders:

Professor John Saunders will be our guest speaker at the South Pacific Quarterly Seminar on May 2014. The title of his talk will be "Understanding addictions: perspectives from DSM-5 and ICD 11".

He was the co-chair of the Substance Use Disorders Research Working Group for DSM-5 from 2003 to 2008, though was not closely involved with the subsequent development of the DSM-5 diagnostic criteria. He is a current member of the Substance Use Disorders Working Group of the World Health Organization, which is developing the diagnostic concepts and guidelines for the forthcoming 11th Revision of the ICD (ICD 11).

Book Review: The Happiness Trap

Everybody should read this book (And I never say that)!

When I picked up this book and glanced at the back cover, I noted the "smiley face" bullet points listing off all the things that this book promised to deliver…

- Reduce stress and worry
- Rise above fear, doubt and insecurity
- Handle painful thoughts and feelings more effectively
- Break self-defeating habits
- Improve performance and find fulfilment in your work
- Build more satisfying relationships
- Create a richer and more meaningful life

And I must admit, I rolled my eyes. Those are some pretty big promises for a little book of only a couple of hundred pages.

By the end of the introduction, I felt my cynicism softening. So much so, that I completely applied myself to completing the questionnaire on page 31. The book suggests doing this properly, and taking a good 15 minutes to do it. After that 15 minutes, I was in, *hook, line and sinker!*

So what is this "Happiness Trap"? It's built on 4 extremely pervasive myths…

#1 Happiness is the natural state for all human beings

#2 If you're not happy, you're defective

#3 To create a better life, we must get rid of negative feelings

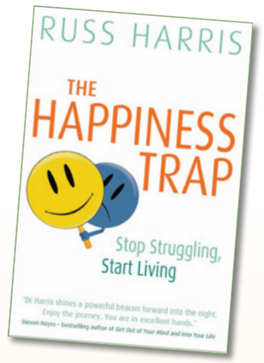
#4 You should be able to control what you think and feel

(If the fourth myth resonates with you, the little "thought control" experiments in the book are both amusing and entirely convincing)

Simply put, the Happiness Trap is the belief that we must feel happy. All. The. Time.

How exhausting, and stressful. And completely unattainable. And, as the research quoted in the book suggests, *"many of us get caught in this psychological trap, a vicious circle in which the more we strive for happiness, the more it eludes us."*

We must learn to feel all of our feelings (not just the "good" ones), as by attempting to allow ourselves only positive emotions, we set ourselves up to fail. Of course! Once you see the trap, you can free yourself.



For healthcare practitioners, the approach discussed in this book will be familiar. Acceptance and Commitment Therapy (ACT) is the escape route that Harris presents us with and it is clearly and simply explained. You may enjoy a simple refresher on the core principles, or you may find it useful to refer your clients to this guide.

About the author: *Dr. Russ Harris is a General Practitioner and leading authority on stress management. He runs workshops for life coaches, psychologists and doctors.*

A Big Step Forward for South Pacific Private

As we move into our 21st year of business, our biggest challenge ever is about to begin with the commencement of our long-awaited renovations.

Once complete, we will no longer have large shared wards, but more single and double rooms, many with ensuite bathrooms. Our beloved Rockcastle Room will be extended to allow room for our 12 extra clients. While the kitchen and dining areas will be on the top floor, allowing for stunning views over the Pacific Ocean.

A labyrinth will take pride of place on the top terrace and at the back of the top floor will be our new larger lecture hall. There will also be a car park underneath accommodating 24 cars. We will also be developing no. 28 Beach Street to provide supported living for clients needing aftercare once they have left treatment.

We expect the work to take 6 months and are looking forward to having celebrations in November, around the time of our 21st birthday. You will all be invited to join us.

No doubt there will be challenges in the months ahead, but we have done it before and don't anticipate that it's anything we can't handle! Watch this space for progress reports…

Psychiatrists Dinner and Discussion Series: Understanding Addiction: Perspectives from DSM-5 and ICD 11

Thursday 22nd May: 6.00pm – 8.30pm

Venue: Wolfies, 27 Circular Quay, The Rocks

Speaker: Professor John Saunders, Consultant Physician in Addiction Medicine, South Pacific Private

Dinner & Discussion Series
SOUTH PACIFIC PRIVATE

What is this thing called addiction? Never underestimate addiction. It is a powerful and destructive disorder, yet it is treatable. Neurobiological research now explains how addictive disorders develop from patterns and habits of use, to powerful internal drives that become less and less responsive to attempts at voluntary control.

Using DSM-5 as a reference point, Professor Saunders will explore this premise and summarise the psychopharmacological, neurobiological, and psychosocial bases of addiction. **Has DSM-5 got it right or has it found itself in a blind alley?**

Professor Saunders was the co-chair of the DSM-5 Substance Use Disorders Research Working Group from 2003 - 2008, though was not directly involved in the subsequent development of the DSM-5 diagnostic criteria. He is also a current member of the Substance Use Disorders Working Group of the World Health Organization (WHO), which is developing the diagnostic concepts and guidelines for the forthcoming 11th Revision of the ICD (ICD 11).

Professor Saunders has appointments at SPP as well as Sydney Medical School, University of Sydney, and in the Faculty of Medicine and Biomedical Sciences, University of Queensland. He was responsible for the development of WHO's ADUIT questionnaire, has published four books and is an ISI highly-cited researcher.

To register your interest in attending email registrations@southpacificprivate.com.au or call the PR department on (02) 9905 3667

The Northern Sydney Partners in Recovery program (NSPIR) is led by Northern Sydney Medicare Local (NSML) in partnership with a broad range of local services and support organisations.

medicare local
NORTHERN SYDNEY
Connecting health to meet local needs

Mental illness accounts for 13 per cent of the total burden of disease in Australia with around 600,000 Australians experiencing severe mental illness. 60,000 Australians have enduring and disabling symptoms which requires complex, multi-agency support needs.

The NSPIR program aims to better support people with complex mental health needs. The program will help people to access services across multiple sectors in a more integrated way. This will be achieved through strengthening partnerships, improving referral pathways & promoting a collaborative recovery model.

The NSPIR model is recovery-oriented and client-centred which is an approach tailored to address the specific support requirements of each individual. The objective of this approach is to maximise the consumer's capabilities through social and environmental opportunities.

A dedicated NSPIR Service Coordinator will undertake a comprehensive assessment of the consumer's support needs and develop a Partners in Recovery Action Plan to guide the engagement and integration of services.

Since the implementation of the NSPIR program, the NSPIR team has been working closely with South Pacific Private. This relationship will help to improve the wellbeing of the local community by improving awareness of each service, shared training opportunities and working collaboratively. The partnership was highlighted by two recent professional events organized by NSML and SPP respectively.

In Jan 2014, Dr Ben Teoh, Medical Superintendent, Psychiatrist and Physician in Addiction Medicine from SPP presented at the NSML workshop "Diagnosis and Management of Mood Disorder - a holistic approach". The workshop attracted 52 professionals including GPs, Psychiatrists and Allied Health Professionals from the NSML catchment areas. On 5 Feb 2014, three members of the NSPIR team attended SPP's Professional Grand Round on Chronic Pain and Addiction.

NSPIR and SPP envisage that this collaboration will facilitate access for NSPIR clients to inpatient and day programs as well as specialised programs offered in SPP, but most importantly aim to improve mental health care for all Australians.

Relapse Prevention: Identifying Stages of Relapse

Addicts in recovery experience a dramatic change in lifestyle; making it through withdrawal and the early stages of recovery stage. However, it can all unravel and a client can find themselves at risk of relapse due to over-confidence and poor life skills.

The following stages of relapse, outlined by Terry Gorski (1982), can be a very helpful tool when working with addicts as they track the effects of this overconfidence, and can help avert them from the perils on the recovery road.

The "Relapse Dynamic"

Gorski summarised the stages of relapse into 11 stages that reflect a gradual sequence of behavioural, psychological and social shifts towards a loss of control. By recognising these stages, it is possible to interrupt their progression.

1. Change

- Changes in daily structure
- Significant stressors
- Work pressures
- Relationship difficulties
- Attitude shift

2. Elevated stress

- Change introduces more stress (distress)
- Sleep disturbances
- Short fuse
- Work performance deterioration
- Relationship / communication issues

3. Denial Reactivation

- Denial of excessive stress (distress)
- Presence of a defensive system
- People asking "What's going on with you? Or are you OK?"
- If you are in a relapse pattern you may find such questions uncharacteristically irritating or intrusive

4. Fragmentation or "falling apart slowly"

- Elevated stress eventually causes significant impairments in the individual's ability to think, feel and act with any clarity or confidence
- Thinking patterns begin to narrow and become difficult to break, and a growing sense of "feeling scrambled" interferes with daily functioning
- Memory problems are frequently seen in this stage
- Emotional inability or reactivity increases as can a general or global sense of numbness
- As the cognitive and emotional processes become more disorganised – behaviour begins to reflect this gradual breakdown
- Panic, anxiety, increased worry; empty feelings, agitation and fatigue may be experienced as indicators of a gradual relapse pattern

5. Behaviour Change

- Action and behaviour reflect the final sequence in the above example
- Although the individual may be going to the same places and associating with the same people, their behaviours will invite unnecessary stress and confusion
- Some will experience irritability, and agitation, whilst others may withdraw and isolate

6. Social Breakdown

- Associated with behavioural changes are subtle differences in the individual's "social feel"; or the sense one gets from being around them
- As a result of this breakdown, the individual may lose contact or cause conflict with regular supports

7. Loss of Structure

- Life structure begins to show signs of alteration and degeneration
- Abandonment of recovery plans, daily routine and habits
- Far more inconsistencies than behavioural change alone
- Increased incidences of sleeping in and avoidance of work, social and relationship commitments

8. Loss of Judgement

- Individual's increasing inability to make decisions, solve problems or continue in recovery behaviours
- What would normally be completed with little difficulty might now be impossible to begin

The art of good therapy is to be able to identify as early as possible when a client has started a decline into relapse. These 11 stages of relapse can make the observations more structured and helpful.

To find out more about SPP's treatment modality or for more info. please email Jacquie Grant on jgrant@southpacificprivate.com.au

SOUTH PACIFIC PRIVATE: 20 Years On…

It has been twenty years since South Pacific Private opened its doors. Much has changed and the hospital has grown and evolved. I recently reflected on our journey and the things that I would worry about:

1. *How would we make clients aware of South Pacific Private?*
2. *The lack of knowledge about Recovery amongst the medical profession*
3. *The attitude to addiction and its treatment in Australia*
4. *The stigma attached to mental health issues*

Today, many of these problems no longer bother us and I am constantly amazed and delighted at the change of attitudes in 20 years.

We are now firmly entrenched in the field of addiction. As time passes, more and more people have a better understanding of mental health issues.

Stigma regarding mental health issues has also decreased as more information becomes available and accessible.

Over the years we have built a solid integrated treatment program with a strong multidisciplinary team. We have identified and treated clients with addiction and mental illness and have developed specific programs to treat these conditions.

Our programs have further expanded to include other mental conditions, including Mood and Anxiety disorders. Our extended Day and Evening programs help clients in their long term Recovery and reduce the risk of relapse.

In summary, the past twenty years have been an amazing journey. The Team at SPP look forward to the next twenty!

With us since day one!

***Rosamond Nutting, B.A.Hons. (Psych), M.Ed.Studs.(Psych), MAPS, MAS Hypnosis** is a registered Psychologist who has been referring clients to South Pacific Private for over twenty years.*

How did your journey with SPP begin?

In 1990 my life was in crisis. At that stage I'd been a Registered Psychologist for eight years and knew that I needed help to sort my life out. I knew I needed to change but didn't quite know how to. The opportunity came during a workshop given by Pia Mellody in Sydney that same year, 1990. Pia invited me to 'The Meadows' in Arizona, USA to experience their four week recovery program and after that, complete an Internship as a staff member. It was one of the greatest gifts I've ever been given.

I became passionate about the need for a recovery centre in Australia and was excited when my friends Lorraine and Bill Wood decided to found one in Sydney. I knew that there were so many people here who would be able to receive the same help, support and recovery that I'd experienced in Arizona.

Lorraine and Bill were committed to the recovery processes developed by 'The Meadows' and it was a joyful feeling to know that so many Australian lives were about to change for ever from the extraordinary experiences their centre 'South Pacific Private' would offer.

What is the value of sending clients here and why have you remained supportive of SPP for all these years?

It has now been twenty years since I sent my first clients to South Pacific Private and I love to see the difference in them when they return hopeful, joyful and treading a very different path in their lives. They learn so much about themselves and other people during their recovery processes at South Pacific Private.

Their empathy and compassion increases towards themselves and others and I never ceased to be amazed and uplifted by the human spirit within

even the most dysfunctional individuals returning from their experience. So many clients tell me of surviving the most awful torture as children and some of them were caught up in medicating their ongoing pain with substances or processes in a vain effort to try to block out these past memories.

I'll always recommend that they experience the multi-disciplinary treatment at SPP in order to begin the long task of resolving their past traumatic experiences and move onto a happier future.

While at SPP my clients report feeling their self-esteem improve to heights unimaginable to them prior to their therapy. They begin to feel stronger. They begin to know who they are. In many clients I hear them return saying 'I have never felt so good about myself' and in this place of self-liking for the first time in their lives it is possible for them, with the help of the experienced, insightful, caring, supportive SPP therapists, to confront their own destructive behaviours and the addictions that have the potential to destroy their lives, their relationships with their partners, children, friends and their families of origin.

It is so important for them to let go the baggage of their childhood and adolescence, resolve some of the big issues directly with family members during SPP's 'Family Program' and to open the door to a healthier future; a future of choices, of understanding and of hope.

What advice can you offer to healthcare professionals who haven't yet engaged in SPP and who perhaps don't understand what we do here?

This question really struck a chord in me. I've noticed during my long experience in private practice that if a counsellor/ therapist is confronted by a patient/ client's traumatic story, unless that professional counsellor has resolved their own past childhood traumas, mistreatments and/or neglect, they have a strong tendency to avoid, minimise or shut down their client's feelings and divert the focus of the session to a less emotionally challenging issue.

What I imagine happening is that it seems to be far too threatening for them to listen because the story is most probably 'triggering' their own unprocessed touchstone memories. Also, if *they don't fully understand the impact that these traumatic experiences have had on that individual sitting in front of them, how then can they possibly grasp the concept of 'recovery'?* How can they understand the benefits of the SPP process for this person?

My advice would be to educate yourself around options for patients who are in crisis and to consider SPP as an option for these clients. In addition, my advice would be to assess your own personal triggers to working with clients in crisis.

How has SPP helped your clients to break the circle of 'hurt' they have experienced in their lives?

Unfortunately, one of the adult behavioural outcomes of trauma in childhood is the repeating of traumatic, painful experiences, either by being emotionally and/or physically hurt again in abusive relationships or 'acting out' abusive behaviours on their partners, children, friends, work colleagues/ subordinates, and if they are in positions of public office, the damage to others can be horrific. In other words, 'Hurt people; hurt people'. So, by resolving childhood and adolescent trauma which is at the heart of the SPP process, it is possible to break this destructive, toxic cycle. Wouldn't it be a better world if more people were able to break this cycle of abuse?

Is there a stand-out story that you'd like to share that epitomises the working relationship between your practice and SPP?

Whenever someone shares their story, their feelings and their truth, I feel really honoured that they have chosen me to be close to at that moment.

To see a lost, broken soul set off for SPP with very little hope for the future and no trust in their own ability to overcome the stranglehold an addiction has over them. Then to have them return four or five weeks later with their head held high, a smile on their face and a will to turn their life around…that's why I continue to 'trust the process' at SPP.

To contact Rosamond, feel free to email roznutting@gmail.com

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