



Review Article

Developing Illness Awareness and Self-Agency of Addicted Patients to Predict Risk Situations and Reduce Relapse

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Abstract

Addiction is a physiological and psychological and social disorder that is considered a major health problem in many societies. This disorder is associated with difficulties in the ability of addicted patients to resist and prevent self-destructive and risk situations. This has led to numerous studies that have managed to demonstrate that there is a relationship between the self-efficacy and motivation of these patients aimed at changing addictive habits, even being considered as predictors and/or mediators of the effects of treatment. This article proposes to understand self-efficacy in a broader way (self-agency) that goes beyond the cognitive and behavioural aspects necessary, which also includes an adequate level of self-regulation, commitment and lifestyle changes, all of which are necessary to obtain successful and stable therapeutic results over time.

Keywords: Addiction; Illness awareness; Self-agency

Introduction

The prevalence of alcohol consumption is high worldwide and this risk behavior has been shown to lead to numerous physical and social consequences [1]. Furthermore, it is considered one of the main causes and/or risk factors for chronic diseases [2]. According to the World

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Alcohol and Health Situation Report presented by the World Health Organization [3], Chile is the Latin American country with the highest average consumption of pure alcohol per year, causing approximately 10% of deaths at the national level. According to statistics reported by the Eleventh National Study on Drugs in the General Population of Chile [4], the prevalence of alcohol consumption increased significantly from 69.1% in 2012 to 79.1% in 2014. This increase was seen in both sexes and in all age groups, except for young people, who showed no significant change from 2012. The highest prevalence of consumption was observed at the high socio-economic level (52.5%), compared to the medium and low level (46.1% and 46.5%, respectively). A systematic increase has also been observed in marijuana use since 2010. Lifetime prevalence of marijuana use increased from 23.0% in 2012 to 31.5% in 2014, regardless of gender, socioeconomic status and age range and has even doubled in people over 35 years of age.

According to the results of the national study on the burden of disease and the burden attributable to risk factors in Chile [5], alcohol consumption is the leading cause of Healthy Life Years Lost, since it ends up affecting a person's psychological well-being and functioning in different areas of their life, producing a considerable deterioration in physical health and social functioning [6,7]. According to the World Health Organization [8], quality of life is defined as the way a person perceives his or her life situation, cultural context and the values in which he or she lives, in relation to his or her own goals, expectations, values and interests. Although quality of life can be measured in various ways, the minimum dimensions to consider are the physical, psychological and social Brewer aims [9-11], so that the greater the severity in any of these domains, the lower the level of self-perceived Quality of Life will be [12,13].

Numerous studies have demonstrated the relationship between improved quality of life for addicted patients and staying abstinent [14,15], as well as the inverse relationship with deterioration during relapse [16,17]. Bottlender & Soyka [18], found an association between a low level of awareness and a higher probability of relapse during their first year of abstinence, so the degree of motivation of the patient before starting treatment seems to be a key element for change, especially if they have managed to stay in abstinence before.

Relapse of a patient after a period of abstinence may be the result of maladaptive ways of coping with stressful situations of everyday life, which are characterized by an imbalance between the demands on the environment and the skills or resources of the patient [19,20]. Therefore, it is necessary to train social skills, coping skills and behavioural changes to cope with such situations [21]. In this sense, Monti, Rohsenow, Colby and Abrams [22], proposed that the patient should develop the following 4 social skills to be able to adequately cope with such situations:

- Interpersonal skills to establish better social relationships;
- Cognitive-emotional coping skills to achieve that of mood regulation;

- c. Skills that allow for improved quality of life;
- d. Skills for the identification of signs related to consumption.

Shand, Gates, Fawcett and Mattick [23], showed that the development of these skills is often more effective in intensive treatment programs, while de Sá and Prette [24], propose that the ability to anticipate is the most important coping strategy for maintaining abstinence.

Donovan [25], describes a coping strategy called the anticipatory strategy, which allows the individual to consciously and assertively identify his or her consumption desires. By using this strategy appropriately, the person's thoughts and behaviors are focused on building environments that are less susceptible to risk situations, on the one hand and on quickly and effectively resolving the danger before relapse occurs, on the other. However, people with chemical dependency are often highly impulsive, preferring small and immediate rewards, rather than larger and later ones, without necessarily assessing the pros and cons of the various options [26].

One of the main consequences of the consumption of illicit drugs and alcohol is cognitive dysfunction resulting from the deterioration of the person's awareness of the disease. This deteriorated or altered perception must be considered as a kind of continuum, ranging from a total denial of the disease, underestimating the multiple consequences in daily life due to consumption [27,28], through a deficit in autobiographical memory [29], to the total and conscious recognition of suffering from a chronic disease [30].

In fact, although it has been possible to identify different brain structures that are susceptible to the effects of chemical consumption [31-33], clinically the lack of awareness of illness has been associated with problems at the motivational level and with denial [34]. Thus, substance abuse appears to be incompatible with a person's thought processes, especially those related to the ability to pay full attention, voluntarily and consciously, as a result of the lived experience, in the moment itself and without attributing any value to them or connecting them to past memories, emotions or thoughts [35,36]. Consciousness, like full attention, has as its distinctive features to be thorough, efficient, but above all to remain oriented to the accomplishment of certain tasks [37]. In that sense, it has been observed that the ability to act with conscious attention is negatively associated with excessive alcohol use [38] and even more so when the person has consumed more than one substance [39]. Deficits in these executive functions predispose individuals to alcohol abuse [40], under the assumption that poor inhibitory control coupled with poor decision making ends up making the difference between a person choosing decisions that lead to advantageous outcomes, or choosing options that lead to unfavorable consequences [26,41]. Evidence of this is that relapses are generally characterized by a suppression of thought [42,43].

Most of these studies agree on the need to identify protective factors to prevent risk behaviour and possible relapses. Another factor that has been studied recently is the attention to the trait mindfulness [44-47], which has been analyzed together with other variables that could influence this relationship (e.g., phases of full attention, type of substance and characteristics of the sample and severity of consumption, among others). Baer and colleagues [48], propose the following 5 dimensions for understanding attention to the trait:

- a. The person must be able to observe and attend to one's own internal and external experiences;
- b. One must be able to describe and express them verbally;
- c. One must act with awareness present in one's activities;
- d. One needs to assume a non-judgmental posture of one's thoughts and feelings;
- e. One must allow those thoughts and feelings to come and go without attachment (non-reactivity).

Some studies have shown that not acting reactively, but rather acting consciously and without judging oneself, are the dimensions most frequently related to the decrease in consumer behavior [38,49-51], since, in order to do so, the person requires higher order cognitive processes [52]. Therefore, impulsivity is one of the dimensions that could be explaining the relationship between the level of attention to the trait and the consumption behaviors [53,54], biases in attention [55] or stress tolerance [56]. However, a negative relationship between trait attention and substance use may be reciprocal, meaning that increased attention to the trait is associated with increased protection from substance use [57], while increased substance use may be associated with decreased attention to the trait [52,58].

Studies have shown that people with a high level of attention to the trait tend to be less likely to use substances because they tend to perceive aversive experiences as passing situations, rather than as a way of coping [59-61]. People who are less aware of situations that could mean high risk, or of the consequences of these, are associated with an increased susceptibility to automatic drug-seeking processes and with a lower propensity to search for appropriate and effective coping strategies that allow them to pay conscious attention to their own desires to use [62]. In this sense, an individual's thoughts about his or her illness play an important role in how he or she will respond to risk situations. A person who is able to perceive that his or her behavior leads to outcomes that are valued as negative will generally tend to make changes; however, when he or she is unable to avoid or resist risk situations despite wanting to do so, the result will be a cognitive dissonance characterized by much dissatisfaction, which over time ends up changing healthy beliefs, rather than risk behaviors. Along the same lines, Bitarello do Amaral, Lourenço and Ronzani [63], propose 2 main types of beliefs that characterize addict patients: risk-minimizing beliefs and functional beliefs (The first has to do with perceiving less possibilities of experiencing negative effects, or, downplaying the negative or undesirable consequences of a behavior (e.g., "I have not had and would not have negative consequences on my work performance due to my consumption"), while functional beliefs are those that relate to the perception of benefits from engaging in certain behaviors, which are valued as positive (e.g., "I use alcohol because it helps me reduce stress") [64].

The recovery of patients with chemical dependency will be greater to the extent that they can develop a higher level of awareness of their illness, which translates into a greater subjective sense of happiness, a decrease in symptoms and a positive change in their interpersonal relationships [65-69]. However, this recovery also implies the realization of a series of lifestyle changes, which basically have to do with achieving a transformation of identity, understanding the latter as a multidimensional, fluid and context-dependent construct [70], implies that the person, on the one hand, is able to leave aside the identity of the 'drinker', while at the same time managing to develop and internalize a new 'non-consumption' identity that is stable and of which he

or she is fully aware [71-75]. This change in lifestyle is directly associated with changes in the person's quality of life, which is why it has become one of the most studied indicators of therapeutic intervention in drug dependence in recent years [11].

These lifestyle changes are associated with increased self-agency by the patient, that is, a greater degree of self-efficacy in predicting risk situations and decreasing the likelihood of relapse, on the basis that people with greater awareness of illness would tend to repeat certain behaviours when they gain confidence in their ability to make correct decisions [76]. This is in complete contrast to what Bottlender [18], calls short-sightedness of the future, to refer precisely to a person's inability to foresee situations and learn from mistakes. In this sense, it is to be expected that patients with high positive expectations regarding their consumption behaviour (e.g., "Getting clean doesn't mean staying abstinent for the rest of my life") will have unsuccessful therapeutic results, unlike those who have high negative expectations (e.g., "The urge to consume alcohol can lead to isolation from family and friends"), precisely because they will be able to anticipate the negative consequences of their decision to consume [77,78].

On the other hand, a positive relationship has been observed between the use of adaptive strategies as a form of self-agency and improved treatment adherence [79,80] and a negative relationship with relapse rate [81-83]. These results should be taken into consideration as an essential element when designing and implementing interventions to ensure the successful recovery of these patients, including relapse prevention [20].

This entire theoretical and empirical framework was used by Valdés, Quevedo, Arriagada, Borzutzky and Schilkrot [78], to develop a questionnaire to estimate the degree of disease awareness of addicted patients receiving outpatient treatment. It was observed that the disease awareness of abstinent addicted patients gradually increased, especially after the sixth month of treatment, when they were able to improve their self-esteem and reduce their emotional pain, allowing them to develop a new lifestyle. This increased disease awareness (self-agency) was significantly maintained between the sixth and twelfth month of treatment. These results are too coincidental with those found by Marquez-Arrico, Benaiges and Adan [84], regarding the need to develop the capacity of emotional expression during risk situations (i.e., "Working on my emotions has allowed me to understand the seriousness of my addiction") and also strategies to modify the meaning of the stressful situation in an attempt to make it less stressful (i.e., "Protective measures are part of my daily behaviour"). However, it is also important to emphasize the importance of the need for patient commitment as a condition for keeping their recovery stable (i.e., "I feel responsible for my rehabilitation process"). All of these capabilities, coupled with the implementation of more adaptive behaviors (i.e., "I can anticipate risk situations or exposures to avoid the urge to consume") and the recognition of the need for positive social relationships (i.e., "My family or closest attachments are important in keeping me abstinent", "I need help learning to live with an addiction problem") [85-87].

Finally, although it is true that there are numerous studies that have shown that the recovery of addicted patients can be predicted by their level of self-efficacy, there are also studies that consider it a mediating variable. However, more research is still needed in this regard, in order to reach more consistent conclusions. This article

proposes to understand self-efficacy in a broader way (self-agency) that goes beyond the cognitive and behavioural aspects necessary, which also includes an adequate level of self-regulation, commitment and lifestyle changes, all of which are necessary to obtain successful and stable therapeutic results over time.

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Conflict of Interest Statement

Author state no conflict of interest.

Ethical Approval

The writing of this article did not involve any studies with human participants or animals performed by the author.

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