Models of Addiction

Arnold M. Washton, Ph.D.
Disease Model Assumptions

- Addiction is a biologically-based syndrome with psychological and social components affecting its expression
- “Brain allergy” to psychoactive substances
- Predisposition is invisible (can be inherited)
- Once the addiction “switch” in the brain is turned on, it can’t be turned off
- Addiction remains dormant (in remission) until reactivated by alcohol/drug use
Disease Model
Assumptions

- Inevitably if left unchecked, the disease becomes progressively worse leading ultimately to disability and death.
- The disease is generic to all psychoactive substances, irrespective of the particular substances the person happens to choose.
Disease Model
Treatment Implications

- Lifelong total abstinence from all psychoactive substances is the only acceptable treatment goal.
- Confrontational and coercive tactics are seen as necessary to break through “denial”.
- Successful recovery requires true acceptance of the disease, powerlessness, and surrender to a higher power.
- Recovering addicts are in the best position to help other addicts recover.
The more severe the addiction, the more accurately the disease model describes the problem-

- People with chronic, persistent, relapsing addiction
- People with multiple or substitute addictions
- People who suffer severe life-damaging consequences, but continue to use
Disease Model
Limitations & Drawbacks

- Applied indiscriminately to the full range of SUDs even when it is not a good fit
- Ignores and dismisses individual differences
- Ignores that there is a CONTINUUM of alcohol/drug problems
- Promotes a rigid stance that relies too heavily on aggressive confrontational tactics
- Promotes the idea that there is one and only one pathway to recovery for everyone (e.g., AA)
Adaptive (Psychological) Models

- Include a range of psychodynamic, cognitive, and behavioral approaches each based on fundamental beliefs about the nature of addiction and the role of psychotherapy in treatment.
- Substance use is seen as originally adaptive and an attempt to cope.
- Substances initially enhance functioning and thus become potent reinforcers.
Psychological (Adaptive) Models: Assumptions

- People develop SUDs when they need compensatory coping mechanisms (e.g., they are anxious, depressed, traumatized, fatigued, shy, easily distracted, etc.)
- There are unique, complex interactions between:
  - Pharmacology of the drug
  - Setting and circumstances of use
  - Characteristics of the user (physiology, personality, expectations, mood, emotional state, etc.)
Psychological (Adaptive) Models
Assumptions

- By inducing emotional numbness, substances turn off emotional “radar” leading to maladaptive behavior (failure to recognize and cope with problems)
- SUDs are not unique. They can be understood by the same psychological and behavioral principles as other disorders
Psychological (Adaptive) Models

Treatment Implications

- Complete abstinence from all psychoactive substances may or may not be required depending on problem severity and other clinical considerations.
- Exploration of possible contributors to addiction in a person’s developmental history is important, but not in the early stages of treatment.
- Theoretical models and treatment approaches developed with other disorders might be applicable.
**Psychological (Adaptive) Models**

**Treatment Implications**

- The focus of treatment is on “self-medication” aspects of substance use rather than specific drug actions.
- Treatment techniques based on the disease model are not incompatible with adaptive-model approaches and where applicable can be incorporated into the therapy.
**Self-Medication Hypothesis**
*(Khantzian)*

- Addiction vulnerability due to impairments in affect regulation, self-care, self-esteem, and interpersonal relationships
- Some vulnerable people feel too much: overwhelmed by affects, inadequate stimulus barrier, deficient affect management, and self-soothing abilities.
- They are likely to choose depressant drugs (e.g., Alcohol, tranquilizers, opioids)
- May be developmentally rooted in neglect, abuse, trauma, unattuned parenting
Self-Medication Hypothesis (Khantzian)

- Some people feel too little, have an overactive stimulus barrier, are emotionally numb, lack signal anxiety, and have impaired affect recognition skills (i.e., lack emotional “radar”)
- Likely to choose stimulant drugs such as cocaine or methamphetamine
Clinical Implications of the Self-Medication Hypothesis

- Create atmosphere of behavioral and emotional safety (“holding” environment)
- Utilize cognitive-behavioral interventions to teach patients how to recognize, label, and manage internal affects and contain acting-out impulses
- Utilize psychotropic medication to cushion emotional extremes to facilitate learning of affect regulation skills
- At an appropriate point, utilize insight-oriented techniques to address unresolved issues
First, do no harm!

There is a continuum of substance use from non-problematic to extremely problematic and a continuum of substance-related harms as well.

Substance use is initially adaptive (beneficial).

Progression from use to dependence is not inevitable.

Use of intoxicants is a normative behavior occurring in all cultures over many thousands of years.
Harm Reduction

- Treatment should be individualized not boilerplate, respecting the patient’s priorities and goals
- Active alcohol/drug users can and do benefit from treatment
- The relationship with each substance is unique (drug, set, and setting)
- Any reduction in drug-related harm is a step in the right direction whether or not permanent abstinence is achieved
Harm Reduction Approach

Treatment Implications

- Accepts the person “where he/she is”
- Focuses on reducing harm as first priority
- Allows patients to select goals that range from reduced use to total abstinence
- Treatment is based on the rights of individuals to make choices independent of the therapist’s values, priorities, and preferences
Harm Reduction Approach

Treatment Implications

- The development of therapeutic rapport is the foundation of treatment.
- Substance users have needs that go beyond substance-focused treatment, and therapy should address these needs.
- Confrontation is to be avoided in favor of therapeutic techniques that foster engagement, reduce resistance, and increase motivation.
Project MATCH

- Motivation Enhancement Therapy
- Cognitive-Behavior Therapy
- 12-Step Facilitation Therapy
- No difference between groups in retention and outcome
- No difference based on therapist’s recovery status or degree level
- Important differences based on therapists’ clinical style & stance toward patients