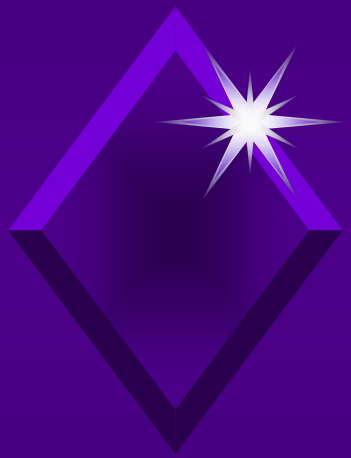

Models of Addiction

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 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**

Disease Model
Treatment Implications

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**

Harm Reduction Approach
Denning (2000)

- 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 susbtance 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**
- **Susbtance 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