WEEK 1: THE NATURE OF ADDICTION

1. Addiction is a complex concept, not easily defined

Our first challenge for the semester is to figure out what we mean by "addiction." When we say that someone is addicted, or suffers from an addiction, or when we describe a chemical, or an activity, as addictive, what do we really mean?

To start, think about anyone you know whom you regard as addicted.

What is the focus of the addiction? Is it some type of drug? What drug? What about alcohol? Nicotine? Caffeine? Does it have to be a psychoactive chemical? What about food? Does it have to be something we ingest? What about shopping, or gambling, or watching pornographic videos?

Regardless of the focus, now think about what it means to you to say that the person is addicted. How do you know? What are the observable signs?

To be more specific, imagine that you have been carefully observing ten different people for some time, all of whom drink alcohol or use other drugs, some of whom are addicted and some of whom aren't. For those who are addicted, what would be the telltale signs? How would you know? What would be the evidence that would convince you that these people are addicted? If simply observing them doesn't tell you enough, imagine you could also question them at length. What questions would you ask and what answers would you need to obtain to help you to figure out which of them is addicted?

A related challenge is trying to distinguish between addiction and other similar problems that people might have. For example, there are lots of people who have a drinking problem, or who misuse drugs, or who lose money gambling, but surely they are not all addicted. So we're not just trying to draw the line between "addicted" and "normal;" we're also trying to draw the line between being addicted and other types of problems people might have with chemicals or other pleasurable activities.

Over the years, many possible answers have been proposed, and there is no clear consensus on what the core components of an addiction are. For our purposes, we will start off with a fairly neutral definition, one that primarily focuses on strictly observable qualities:

Addiction is a term that is applied to patterns of behavior that involve the following observable characteristics:

- the behavior is excessive
- the behavior provides some short term psychological gain to the individual that operates as a powerful inducement to engage in the behavior
- the behavior carries with it a high risk of negative consequences
- the behavior persists even after negative consequences occur
- inability to engage in the behavior will be associated with visible signs of distress
in describing their actions, people often uses such words and phrases as “need,” “crave,” “must have,” “can’t live without,” “can’t help myself”

Another definition can be found in the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) published by the American Psychiatric Association (1995), the reference used by most mental health professionals in the U.S. today. DSM-IV, as it is known, uses the term "dependence" instead of "addiction," and applies it to a certain pattern of use of psychoactive chemical substances:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve the desired effect, or (b) markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance (consisting of specific physical and psychological symptoms) occurs when use ceases, or (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Note that these definitions merely describe addiction. Although we sometimes use addiction as an explanation, this is an example of what we call circular logic: he drinks too much because he's addicted/he's addicted because he drinks too much. In other words, addiction is a property of the behavior itself, not some hidden force that causes the behavior.

2. Addiction is also not easily understood

As we just saw, addiction is not easy to define.

A separate issue is how we understand or explain it. This, too, is complicated, because addiction can be conceptualized in several different ways. In his opening chapter, Thombs distinguishes between:
1. the **disease** models, which regard the behavior as symptomatic of an underlying physiological disease
2. the **moral** models, which regard the behavior as indicative of some moral or personal weakness or defect of character
3. the **psychosocial** models, which regard the behavior as a learned response, shaped over time by the person's environment

In other words, addiction can be viewed as a **sin**, as a **sickness**, or as a **habit**. Depending on which of these views you adopt, you will come to very different conclusions about whether or not the addict should be held responsible for his actions, whether or not the addict can solve the problem himself, and what the proper solution should be.

In Chapter 1, Thombs offers a brief summary of how attitudes about alcohol and problem drinking have evolved over the past 200 years, with particular emphasis on understanding how the disease concepts of addiction have developed.

Another difficult question about addiction is whether it is the substance/activity that is **addictive**, or is it the person who is **addicted**? Are only certain substances or activities addictive, and if so, what property gives them that addictive power? Are only certain people addicted, and if so, what makes them so vulnerable?

A related issue is where the addiction resides:

- Is addiction in the cells and tissues of the body?
- Is it in the mind or personality of the addict?
- Is it an irresistible feature of the substance or activity?
- Is it a function of environmental conditions, temptations, pressures?

Because there are so many possible ways of thinking about addiction, there are all sorts of questions that are difficult to answer and about which even the "experts" disagree.

For example, do you think it is right to punish an alcoholic (or drug addict or compulsive gambler, etc.) for drinking too much, or for what he does while drunk? Do you think that it's just a question of willpower for an alcoholic to stop drinking? Can an addict cut down, or is it necessary to stop altogether? Can someone use a drug like heroin without inevitably becoming addicted?

As Thombs points out, the view of addiction as disease has a long history, first presented by physicians like Benjamin Rush in the late 1700s. Yet it is interesting to note that by way of contrast, if we look at the history of opiate use in the U.S., for a long time such drugs were legal and were **not** perceived as addictive! So our understanding of addiction is complicated by possible differences in the focus of the addiction. Alcohol vs. drugs? And what about supposed addictions to food? Can food be like a drug? And can we be addicted to an activity as opposed to a substance? Gambling? Shopping? Text-messaging?

**Addiction vs. Compulsion**
Another source of confusion is that we have two terms often used interchangeably: “addiction” and “compulsion.” Do these two words describe the same state, or different states?

A distinction that many have found helpful is to think about what drives the behavior. If you look back at the previous page and my first definition, you will see that my second bullet referred to “psychological gain.” I mean this to emphasize that the starting point for addiction is the pursuit of pleasure and that only those substances (or activities) that provide pleasure can become addicting.

In contrast, a compulsion is driven by the need to do something that one fundamentally does not want to do. There is no pleasure in it, just a desperate need to do it, perhaps to ward off negative feelings. Some use a pressure-cooker analogy: the pressure builds inside to engage in some pointless or foolish or even harmful behavior, to the point that the person feels that he will explode if he doesn’t give in. And by giving in, the person releases at least some of the pressure, until the pressure builds again and the cycle is repeated.

So while compulsive behaviors might also be excessive, they are not classified as addictions. This means that there are many other areas of troublesome human behavior that share some similarities with addictions but that are not usually seen as true addictions. This would include obsessive-compulsive disorder (OCD) and the eating disorders of anorexia and bulimia (which, for this reason, are not acceptable as a focus for a term paper in this course).

And yet even this distinction can be debated, because for many addicts, especially in their later stages of addiction, the continued involvement in the addiction often becomes more driven by desperation, by the “compulsion” to stave off the terrors and torments of withdrawal.

**DSM and Addiction**

And if things aren’t confusing enough, the Diagnostic and Statistical Manual that I referred to on the previous page (DSM), which as we saw uses the term “dependence” rather than “addiction,” also has a concept of what it calls “abuse,” as in substance abuse, drug abuse, etc. And most would argue that abuse is not addiction. Yet in substance abuse programs, drug addiction is treated. And when members of Alcoholics Anonymous talk about alcoholism, it is clear that they include both abuse and dependence. Go figure!

You should also know that DSM-IV came out in 1994, and at the time there was dissatisfaction with how it created one category of what have been known as Substance Use Disorders, and a totally separate category of what it calls “Impulse-Control Disorders Not Elsewhere Classified,” which includes, among others, pathological gambling.

And the category of “Impulse-Control Disorders Not Elsewhere Classified” also includes several manias: pyromania and kleptomania, which you’ve probably heard of, and
trichotillomania, which you probably haven’t—look it up. In fact, a 19th century psychiatric term for what we now often call alcoholism was dipsomania. The origin of all these “manias” lies in the dictionary meaning of the term mania, which is different from the mood-related meaning it has taken on in mental health circles (“manic-depressive”): a mania is “an excessively intense enthusiasm, interest, or desire.”

We also have the popular terms “sex maniac” and “nymphomaniac,” the uncontrolled desire for sex, also known more technically as “hypersexuality.” Yet DSM puts all these sexual excesses into yet a third category, simply called “Sexual Disorders,” where we find the exhibitionists, voyeurs, sadists, masochists, and all the “—philes” (unnatural and inappropriate sexual desire): pedophiles (young children), necrophiles (corpses), coprophiles (feces), etc.

The plan is to publish the new edition, DSM-V, in 2013. By all accounts, it will include a category of “Addiction and Related Disorders,” which will include “Substance” addictions—alcohol and other drugs—and also quite probably some forms of “Behavioral” addictions, including gambling and possibly hypersexuality. And it appears that the tolerance criterion I listed on the previous page will be de-emphasized, because we know that people who are given prescription narcotic drugs can develop a tolerance, but we don’t usually think of them as addicts unless they continue the use after the prescription is no longer needed (an obvious example would be oxycodone/OxyContin).

A Look Ahead

Given all these complexities, it should come as no surprise to you that over the years the experts in this field have come up with many different ways of understanding addiction. Over the next several weeks, we will examine the major theories:

- Disease models
- Behavioral genetic and psychobiological theories
- Person-centered theories
- Behavioral and learning theories
- Social learning and cognitive theories
- Developmental models
- Family systems theories
- Societal and cultural perspectives

3. We need to approach our study of addiction very carefully

In the previous topic, we saw that the task of defining addiction is very challenging. In this course, our framework for the study of addictions is psychological, and the field of psychology is a fascinating mixture of theoretical perspectives, scientific research, and professional practice.

Let’s begin, as Thombs does, with theory (also sometimes referred to as model). Contrary to popular usage, scientists use the word theory as related to, rather than the opposite of, fact. In other words, we don’t dismiss an idea by saying, "Oh, that's just a theory."
A theory is our way of imposing order and meaning on information, a way to organize all the information available to us to enable us to make some sense of complex phenomena.

Thus, theories are derived from facts (research data, observations). In turn, theories are tested through further collection of facts, which will lead to acceptance or modification (and sometimes rejection) of existing theories, and then the new or revised theories are put to further test, and so on.

Some theories are better than others, and on page 11 Thombs lists five criteria by which you might assess the value of any theory or model: clarity, comprehensiveness, explicitness, parsimony, and its ability to generate useful research findings.

For me, as both an academic psychologist engaged in teaching and research, and as a clinical psychologist who has worked with hundreds of clients over the years, the last point above is especially important. I view psychology as first and foremost a science, and while I respect everyone's right to an opinion, I always look for the research evidence. Scientists are very skeptical people, and it takes a lot of hard data for them to be convinced that a certain proposition is probably valid.

What about professional practice? Because psychology is both an academic discipline and a profession, we have a model of what has been termed the "scientist-practitioner." A good practitioner should draw heavily on the most up-to-date theory and research, and a good scientist should view practice as an important arena for gathering more data and for testing theories.

Unfortunately, as Thombs points out, in the U.S. there is a very deep schism between science and practice. A lot of what is presented by addictions professionals and widely accepted by the general public today is unsupported by any hard evidence.

How has this unfortunate situation come about?

- Many addictions treatment personnel are not rigorously trained in academic fields that emphasize science
- The addictions treatment field has placed major emphasis on what scientists call "testimonial evidence," the personal stories of people who have struggled with their addictions, but testimonial evidence is deeply flawed, and opinions based on such evidence are very likely to be inaccurate
- American culture has become increasingly "medicalized" - we are taught that just about every human problem can be explained as some sort of disease, and we look to medical science to find a cure for virtually everything that ails us

At the same time, the research community is not entirely blameless either. As Thombs points out, laboratory research, with very carefully selected subjects studied under very controlled conditions, often has little relevance to an addictions counselor struggling under the burden of a heavy caseload of seriously impaired clients.
(A major purpose of this course will be to challenge the conventional thinking that dominates the field of addictions treatment in the U.S. today and to focus closely on what science can tell us. As we look at theories of addiction, we will also look at how these theories can be translated into effective interventions, again emphasizing what science can tell us with respect to what some are now referring to as "Evidence-Based Practice.")

Starting SOON, we will devote several weeks to a review of theories within the major perspectives of psychology: biomedical, person-centered and psychiatric, behavioral, social-learning and cognitive, developmental, and socio-cultural. As we examine all these different points of view, keep your eyes on the evidence, and be sure to engage in what I call "healthy skepticism" - ask the right questions, look for the supporting data, and don't accept an idea as true just because a lot of people say it is. Here are some suggestions to help you to be a good critical thinker:

1. You should always be asking questions (and though you might never meet me, please use Chat and Discuss to pass along your questions)
2. Try to frame your questions as "empirical" questions, that is, as questions that can be answered by observing and testing reality
3. Focus on the evidence - opinions are important, of course, and everyone is entitled to them, but always look for substantiating evidence
4. Evaluate the evidence - how much evidence is there, how good is it?
5. Consider other possibilities - even when the evidence supports a particular point of view, there may still be validity in alternative ideas
6. Watch for hidden assumptions and unspoken biases - we often accept ideas as true because they fit with previously held beliefs
7. Be wary of appeals to emotion - critical thinking is essentially a process of reason, and gut feelings and passionate beliefs rarely illuminate complicated problems
8. Look beyond the obvious - appearances can be deceiving, and specific examples, however fascinating, cannot be proof of a general proposition
9. Avoid oversimplifications and overgeneralizations - even when ideas are true, their truth is usually limited to very specific circumstances and conditions, which is why "It depends" is so often a good way to begin looking for an answer
10. Don't rush to judgment - always be aware that there is so much we don't yet know, and that a premature answer which is false might do more harm than no answer at all - as has often been said, "It is more important to question an answer than to answer a question"