Freud was convinced that human behavior could best be explained by probing deep into the psyche

Although not a commonly-used term, I like to use the term “personological” to refer to a wide range of theories, often referred to as theories of personality, that emphasize the importance of an individual’s personal psychological experiences, such as needs, feelings, drives, thoughts, perceptions, attitudes, memories, conflicts, etc.

These theories can also be referred to as “psychodynamic,” because they see behavior as shaped by underlying psychological forces, or psycho dynamics. Although they have branched out in many different directions, they all can be traced back to work of Sigmund Freud.

Freud was a Viennese psychiatrist who began treating patients in the 1880s, and he developed and a method of treatment and a theory of personality, both of which are known as psychoanalysis, which is regarded as the first psychodynamic theory. Through his long career (he died in 1939) he wrote extensively and attracted numerous followers, establishing psychoanalysis as the first modern, psychologically-oriented theory of personality, psychopathology, and psychotherapy.

[A curious footnote here is that Freud is also viewed as one of a few individuals responsible for the European and American "discovery" of cocaine, a drug native to South America and widely used by native Americans for centuries that Freud heard about and became fascinated with for what he initially saw as its powerful anti-depressant properties. He prescribed it to friends (and might possibly have used it himself -the historical record is unclear) until eventually realizing that its dangers exceeded any benefit, but by then his "discovery" had spread across Europe and the U.S.]

Freud began his psychiatric career at a time when psychiatry was almost exclusively biological - for example, consider the common term "neurosis:" The "neur" prefix is the same as in "neuron" and "neurology," and the term was originally used to describe a number of maladaptive emotional disorders that were assumed to be neurological diseases. Freud was one of the first to focus much more on psychological factors, and he was very careful to use the term “psychoneurosis.”

His most basic—and probably still his most influential—discovery was what he initially referred to as the "talking cure" - allowing his patients to talk freely, often about very private and intimate matters, he noted that many of them seemed to get well. In a very real sense, all modern modes of psychotherapy and counseling draw their inspiration at least in part from his work.

Over several decades, Freud refined his techniques, and to this day psychoanalysis consists of the techniques he first developed, all designed to help the patient achieve insight, a goal now shared by many other psychotherapies:

- free association
- interpretation
As he developed and became increasingly confident in these psychoanalytic techniques, Freud also wanted to know why they worked, thus leading him to develop the psychoanalytic theory of neurosis and the broader psychoanalytic theory of personality.

Initially, based on what his patients were sharing with him, he took a simple view of neurosis, often referred to as the *traumatic* model:

1. His patients had suffered various forms of early emotional pain, usually of a sexual nature
2. The mind blocked out this pain (repression), and the emotions and memories remained locked deep in the psyche (the unconscious)
3. Over time, the pressure of the psychic energy of these repressed emotions built up to the point that the energy leaked out and formed symptoms
4. The recovery of these repressed memories and the release of all this pent-up emotion (catharsis) were key to the cure

However, early in his career he made a profound shift in his thinking: unable to believe that so many of his patients could really have suffered so much early sexual trauma, he decided instead that the memories were "screens," concealing the underlying *wish*.

Thus, Freud shifted from a focus on his patients' actual experiences and concentrated instead on their psyches; this led him to the following ideas:

✓ The psyche operates both at conscious and unconscious levels, with the Unconscious by far the more important
✓ The psyche is divided into three major subsystems: id, ego, and superego: the id is the most basic subsystem - it is the link between biology and psychology because it is dominated by "instinctual" drives that, in accordance with the pleasure principle, constantly seek immediate gratification; the ego, in accordance with the reality principle, develops to find ways to satisfy demands of the id while still ensuring survival; the superego develops as the internalized voice of civilization and attempts to restrain both id and ego through adherence to standards of right and wrong
✓ These subsystems are always in conflict with each other
✓ This conflict produces the experience of anxiety, which the ego must protect itself from by the use of a variety of unconscious defense mechanisms which keep forbidden desires and painful memories out of awareness
✓ Some of these mechanisms are reasonably healthy and can facilitate successful adaptation, but many are unhealthy and/or not fully successful, thus leading to maladaptive personalities and symptoms
✓ Repressed material contains energy and seeks expression; even in healthy people, the material occasionally surfaces, though in disguised forms (dreams, slips of the tongue, myths, etc.)
All these processes exist within a developmental framework, dominated by the stages of psychosexual development, with the blueprints of our personality pretty well established, for better or worse, by the onset of the latency stage around age 5 or 6.

Freud was convinced that the driving forces in personality and neurosis were sex and aggression, and he formulated a very elaborate theory of psychosexual development, with its famous oral, anal, and phallic stages and the Oedipus and Electra complexes (children who unconsciously desire to sleep with the opposite sex parent and kill the same sex parent).

Freud's influence on psychiatry (and to a lesser extent psychology) was enormous. However, right from the beginning, his followers branched out in other directions. While still agreeing with many of his fundamental assumptions, some (Jung, Adler, Horney, Sullivan, May) emphasized other fundamental dynamics (the need to belong, the need for acceptance, the need to feel powerful, the need to establish a sense of identity or to find a sense of meaning and purpose to one's existence, the anxiety that stems from recognizing one's mortality, etc.). Despite their differences, one can argue that all these views share some basic assumptions:

1. Behavior is motivated, and these motivations explain behavior (psychic determinism)
2. Motivations are shaped by early experience (historical determinism)
3. Motivations operate largely outside of conscious awareness or rational control (unconscious determinism)

Others, who have preferred to call themselves “humanistic” psychologists, have put more emphasis on the role of the ego and adaptive forces in human development, focusing more on conscious processes related to self-esteem and personal growth, and more on the present and future than on the past (Perls, Erikson, Maslow, Rogers).

Freud himself had little to say about addiction, but as well will see, these psychodynamic theories have generated many interesting ideas over the years.

**Though interest in Freudian theories has declined, there are many contemporary psychodynamic theories of addiction**

Freud had numerous early followers, many of whom disagreed with him and went on to develop competing psychodynamic theories (like Alfred Adler and his concept of the inferiority complex or Carl Jung and his concept of the collective unconscious).

Other followers remained within the Freudian camp but began to put more emphasis on aspects of personality that they felt Freud had neglected; these so-called “neo-Freudians” (such as Harry Stack Sullivan, Erik Erikson, Melanie Klein) placed more emphasis on social aspects of development and on a fundamentally healthy ego.

A variety of other theories have appeared over the years that are fundamentally psychodynamic but with very different views about “what makes us tick”; existential
Psychologists, for example, emphasize the fundamental feeling of aloneness and the powerful search for meaning; Abraham Maslow introduced the concept of self-actualization and said that we also had to study healthy people; and Carl Rogers developed a model of "client-centered" therapy that placed people's self-image and self-esteem at the center of psychological functioning, arguing that it was the "human" relationship of client and therapist that mattered more than complicated intellectual analyses.

Much of "pop psychology" is also psychodynamic, with the emphasis on inner forces (e.g., our inner child, the Cinderella complex, women who love too much, etc.). In fact, one of the most common phrases we hear these days is about people's issues -- it's not easy to define this term, but clearly it mostly emphasizes what we think and feel and struggle with inside our own head.

[By the way, I personally object to the widespread use of "issues" as a substitute for the word "problems." Please do not ever tell me that someone has alcohol issues. Either he has a drinking problem or he doesn't!]

Similarly, most popular views of addiction are strongly psychodynamic, viewing addicts as people who are somehow driven by inner forces, like cravings and compulsions. Think about your own "theories" of addiction before you started this course -- your own "common sense" ideas about addiction were probably framed mostly in terms of the addict's needs and feelings, pain and loneliness, emptiness, anxiety and depression, etc.

There are many different psychodynamic theories of addiction, but with very varying degrees of empirical support. In terms of science, there is a problem with the fact that psychodynamic approaches, developed mostly by practicing mental health professionals, have always been heavily based on evidence drawn from case studies. Case studies, however, represent an extremely imperfect form of scientific evidence, dependent as they are on the reports of the patients, the opinions and interpretations of the therapists, on non-random samples of cases, on limited use of objective measurements, and so on. In the list that follows, my comments about supporting evidence refer to evidence from more rigorously conducted scientific studies. In the view of most scientists, case studies do not represent evidence; they can only be used to illustrate by way of example.

**Oral fixation**: the addict remains stuck in, or regresses back to, the oral stage, and the drug becomes symbolic of the longed-for security associated with nursing at the breast.

  > No supportive evidence

**Slow suicide**: addiction represents expression of an unconscious "death wish."

  > Essentially untestable

**Weak ego**: those who lack an ego strong enough to adapt successfully to the challenges of life turn to addictive substances or experiences in a desperate attempt to create a feeling of power and control in lives that have become disorganized and
unmanageable; moreover, a deficient ego will be less able to resist temptation, recognize the harm being done, or exercise self-control.

> Evidence indicates that life failure and various measures of ego strength correlate with signs of addiction (but correlation does not prove causation)

**Addictive search:** addicts are people who are fundamentally flawed in their psychological makeup (probably as the result of problems in early upbringing, but perhaps also influenced by genetic predispositions); they experience powerful and insatiable needs and their world is empty and meaningless, so they become easily "hooked" on drugs or activities that provide relief, that fill them up.

> Evidence does support all sorts of difficulties early in life that might leave people vulnerable to addiction

**Addiction-prone personality:** addiction occurs in a certain type of person who is somehow predisposed (by heredity and/or environment) to become addicted, with the actual addiction taking many different forms: alcohol, drugs, food, sex, etc.).

> No single personality type has been empirically demonstrated; various factors have been identified, but they are often linked to a variety of problem behaviors and not exclusively to addiction

**Power motivation:** David McClelland. Better know for his work on achievement motivation, conducted a series of studies on college students from which he reported significant relationships between their need for and fantasies about power (power over others, feeling powerful) on the one hand and their tendency toward heavy drinking on the other.

> One of many personality traits that researchers have looked at, along with other traits such as negative affectivity, sociability, risk-taking, impulsivity, self-centeredness, etc., with frequent reports of correlation with amount of alcohol or drug use, but again, correlation does not prove causation and heavy use does not necessarily equal addiction; moreover, very little empirical research has demonstrated that any of these personality traits can be confirmed as having existed before any signs of addiction (the “chicken-and-egg” problem)

**Addiction as defense:** addicts are people who turn to addictive substances or experiences as a defense against negative affective states (anxiety, depression, guilt).

> Often referred to as the *Self-medication hypothesis*, evidence tends to indicate that negative emotions more typically occur as a consequence rather than as a cause of addiction, and evidence does not support the psychodynamic assumption that one’s "drug of choice" is determined by the affect being defended against

**Motivation to change:** the focus is here is less on causal factors and more on factors that sustain the addiction or that interfere with the addict’s ability to overcome it
Reasonably strong evidence exists to support the fact that motivational counseling, designed to get addicts to acknowledge their problem and to strengthen their commitment to change, is an important part of effective treatment.

Another variation is to examine the influence of some underlying mental disorder or psychopathology

Another example of a personological view of addiction is the current emphasis on addiction as symptomatic of some other psychiatric disorder, or addiction as a complication that frequently develops in people suffering from a variety of mental disorders or underlying personality disorders. In this view, other disorders exist as forces (dynamics) that drive some people into addiction.

On page 128, Thombs quotes from Leeds and Morgenstern a set of assumptions by which psychoanalysts view addiction as symptomatic of some underlying psychopathology. In fact, over the years, whenever psychoanalysts were confronted with the challenge of treating an addict, they typically tried to identify and treat the underlying neurosis (a method, by the way, that generally does not seem to work).

One of the most widely accepted views of addiction that reflects this emphasis on the link to some other mental disorder is what is known as the self-medication hypothesis. This is a pretty straightforward idea: an addict suffers from some underlying disorder that causes him distress, so he turns to some psychoactive chemical to rid himself of his pain (as in the stereotyped image of an alcoholic "drowning his sorrows"). In this view, alcohol and other drugs become like tranquilizers and anti-depressants.

Instead of emphasizing specific mental disorders, a similar view talks more broadly about what has been called developmental lag. Addicts are seen as immature, as evidenced by their "concretization" (inability to articulate feelings), vulnerability to external influence (e.g., peer pressure), and self-centeredness and inability to form mutually-satisfying intimate relationships. In this view, these underlying weaknesses set the stage for later development of addiction.

Common to all these varied theories is the view that addiction is the symptom of an underlying psychological disorder or dysfunction or defect, and that the psychological problems of the addict precede and cause the problem drinking/drugging (as opposed to being consequences).

A similar way of linking addiction and mental disorder is presented in Chapter 4 of Thombs, in his coverage of co-morbidity (which refers to two disorders or diseases occurring together). Using DSM diagnoses of substance-use disorders (substance abuse, substance dependence), researchers have frequently shown significant overlap with other DSM diagnoses, such as: antisocial personality disorder, social phobia, sexual dysfunctions, major depression, posttraumatic stress disorder (PTSD), panic disorder,
If you look at the data presented in Chapter 4, you will see that in many studies of alcohol or drug-abusing or dependent populations, the incidence of one or more of these other disorders has been reported to be as high as 70%. There is virtually no disagreement about the high rate of co-morbidity, and there is wide recognition that co-morbidity makes the challenge of providing effective treatment even greater, especially among adolescents and young adults.

But there is considerable disagreement over how to understand co-morbidity:

- Does the other disorder lead to addiction?
- Does addiction lead to the other disorder?
- Are they both the end result of some common causal factor?
- Studies of co-morbidity are almost always focused on people in treatment, and perhaps those with co-morbid disorders are more likely to end up in treatment, so the reported high rates of co-morbidity might be misleading.

As always, correlation does not prove causation.

**How shall we evaluate these personological theories?**

**Implications for Treatment**

Many mental health professionals assume that addiction is best treated by some form of psychotherapy:

- traditional psychoanalysis designed to assist the patient gain insight into the root causes of the addiction
- modified psychoanalytic psychotherapy designed to shore up and redirect the patient's defenses (for example, Wallace's "preferred defense structure" approach as described in Thombs)

But in addition to, or even instead of, psychotherapy, there is also a lot of emphasis on pharmacotherapy (the use of prescription psychiatric medications). As we have seen, there is a lot of evidence that addicts also frequently suffer from depression and anxiety (though distinguishing cause and effect can be tricky!). Thus, many physicians believe that one should treat the addiction by treating the anxiety or mood disorder, for which anti-depressant drugs like Paxil and Prozac and Zoloft have become increasingly popular. And there are many other anti-anxiety, anti-depressant, anti-psychotic and/or mood stabilizing medications.

In recent years, there has also been interest in the possible link between Attention-Deficit/Hyperactivity Disorder (ADHD) and substance abuse, and an increasing number of adult addicts with diagnoses of ADHD are being treated with stimulant drugs like Ritalin.
One final issue to consider in evaluating these psychodynamic theories involves the emphasis on long-term, intensive, insight-oriented individual psychotherapy. As was previously noted, there is not a lot of evidence of the effectiveness of such therapy with addicts. In fact, some have suggested that this type of therapy might actually do more harm than good, because it is emotionally very stressful, which might only stimulate more addictive behavior.

Moreover, it is based on what many regard as a very controversial assumption: that addicts can be "cured." In other words, if addiction stems from some inner "flaw" in one's psyche or character, and if that flaw can be fixed by psychotherapy, doesn't it then logically follow that the former addict should now be able to safely and responsibly engage in the behavior? Or what if there is some "chemical imbalance," and that imbalance can be fixed by some prescription drug? As we saw in the previous two weeks, there is such widespread belief in the existence of an incurable disease underneath addiction that, at least in the U.S., most substance abuse professionals remain committed to the treatment goal of lifetime abstinence (an opinion that many of you also expressed in Week 1's Discussion).

It is generally accepted these days that traditional, insight-oriented psychotherapy is not the treatment of choice for addiction, at least not in the early stages of recovery. Indeed, many believe that the inherently painful process of psychotherapy will only stimulate more addictive behavior. And treating a drug problem with a drug strikes many people as misguided.

At the same time, there is growing recognition that the "dually–diagnosed" (as those with substance use disorder and some other mental disorder have come to be known) do pose a very special challenge, and there is growing acceptance of what Thombs describes as integrated treatment for dual diagnosis.

Where's the Evidence?

All the theories we have looked at this week suffer from one critical weakness: a serious lack of solid empirical data. This perspective has sometimes been referred to as the "thumb on the hand of psychology," and at its worst, it is the primary example of what some like to call "psychobabble."

This weakness can be attributed to several factors:

- the focus is on what is essentially "invisible" -- we can't actually see what is going on inside people's heads
- as a result of this invisibility, there is a lot of "guesswork," with different theorists coming up with all sorts of different guesses about what might be going on
- most of the key theorists have been primarily involved in professional mental health practice, so their method of research has inevitably relied heavily on case studies, which are an especially weak form of scientific investigation
- with most of the "researchers" being those in practice, their "research participants" include only those in treatment, who might not be typical of addicts not in treatment
therapists are supposed to influence their clients, so can we assume that the client's self-reports are objective and unbiased?
even if the therapy seems to help, that doesn't mean that the theories that guided the therapy were accurate; a therapist could discuss almost anything with a client, and as long as the therapist was warm and caring and supportive, the therapy might help

Thus, when I presented some of the specific psychodynamic explanations for addiction, you might recall that for many of them I indicated that the theories were largely "untestable" or had very little empirical support.

In addition, there is the correlation-causation problem we have encountered before. Even though we often find instances where addiction goes hand-in-hand with certain personality traits, or underlying emotions, or co-morbid disorders, the correlation of such variables doesn't prove causation. For example, consider the connection between, say, depression and addiction; this connection, which has been empirically demonstrated, can be explained in several ways—look at Table 4.5 on page 110 in Thombs:

1. The people who end up in treatment tend to be the sicker ones, who therefore might suffer from both depression and addiction, or
2. Depression causes addiction, or
3. Addiction causes depression, or
4. Both depression and addiction are the common end result of some other cause (for example, an unhappy childhood)

In other words, there is what some call the sampling problem (1 above), the directionality problem (2 and 3 above), or what has been termed the third-variable problem (4 above). With several plausible explanations, there is no way to be certain which is correct, which is why we say that correlation doesn't prove causation. And of course, it could all just be a coincidence; people suffer from two or more problems all the time (have you ever had a back ache and also the flu—must they be connected?).

In summary, based on what you now know about personological theories of addiction, how would you rate them in each of the following areas we identified two weeks ago as the formal attributes of a good theory or model?

- Clarity: are the personological theories clear, well-articulated, easy to understand?
- Comprehensiveness: do the personological theories deal with all, or at least most, of the major issues?
- Explicitness: do the personological theories use precise definitions in a way that allows for reliable measurement of key variables?
- Parsimony: do the personological theories provide a simple way to understand addiction?
- Ability to generate useful research findings: are there good studies with strong scientific evidence to support these personological theories?