1.5 Addiction

As I am making a case for supervision within the addiction counselling field needing to be separate and different from supervision for generic counsellors, it seems pertinent to spend time discussing the main reason for this stance, which is the phenomenon of addiction. The aim of this discussion will be to highlight how the phenomenon of addiction directs and affects the counselling approach taken, in comparison to more generic counselling approaches. This difference in required counselling approach then determines that the supervisory approach also needs to understand and acknowledge those differences.

What is 'addiction'? How has this term been defined throughout history? Do we actually agree on a specific definition, that is accepted across all aspects of the field? The answer to that third question is an unequivocal 'no'! Many authors and thinkers have attempted to define 'addiction', outside of the general dictionary definition as a noun, as both a phenomenon and an ideology, yet we do not have an agreed definition or accepted descriptor to what 'addiction' might be.

William White, writing in 2000, gives a very detailed history of the concept of addiction as a disease *(2000:46-51)* and this notion of addiction being a disease has been part of the thinking around addiction since Dr Benjamin Rush declared it 'a disease of the mind' in 1784 *(White, 2000:48)*. Whilst this notion is still prevalent today, other authors offer a different view.

Miller and Gianni *(1990)* also write about the history of the definitions of addiction, and they too allude to the way that addiction was seen initially as a mental illness associated with a lack of moral character, compared to a more modern view that, as part of a psychiatric disorder, it is more of a medical matter and therefore a medical disease.

DiClemente *(2006)* writes that addictions have impacted on societies throughout history, and that explanations for addiction have often blamed individuals for excessive engagement in addictive behaviours. He goes on to state that scientific theories that are formulated to explain and understand addictions have only been in existence for the past century, and although the explanations may have become more sophisticated, the understanding of addiction from within the field is far from complete.

Cook, writing in Reading and Jacobs' edited text *Addiction Questions and Answers for Counsellors and Therapists (2003)* was invited to answer a question about addictive personality. At the time of writing that answer he was Professor of the Psychiatry of Alcohol Misuse at the University of Kent, and his research interests included the genetics of alcohol misuse and spirituality and addiction. He started his answer by stating

> "There have been many accepted theories of addiction, and some of these are more popular than others. However, it is difficult to justify any one of these as the accepted theory" *(2003: 16)*

He then goes on to explain that there is "increasing evidence that there is a degree of individual predisposition to alcohol-related problems conferred on the basis of genetic factors" *(ibid:18)* His research was alcohol-use specific, so it is not clear from his writing whether this ideology includes other drugs apart from alcohol, or other behaviours, such as gambling, that are deemed 'addictions'. Even so, it is not yet irrefutable proof that addiction is genetic, so the research continues to try to find this particular holy grail.

Another eminent researcher in the field of neuroscience and addiction is Dr Carlton Erikson. The first few pages of his text *The Science of Addiction (2007)* are an interesting discussion about why he does not like the word 'addiction', as he describes it as unscientific, unspecific, and a term that has been misused in common society to describe behaviours, ideologies or processes that are not actually addictions. As examples, he comments on the flippant use of the term 'addicted' to describe people who over-use substances such as coffee or sugar, or who frequently engage in activities such as knitting or the use of tanning booths.

Erikson goes on to discuss how other terms appear within the literature to describe 'Addiction', such as 'alcohol dependence', 'alcoholism', 'drug dependence' or 'chemical dependence'. This reiterates my earlier point about there being no specific description that is universally accepted across the scientific spectrum.

We must also pay attention to the fact that other terms, such as 'drug abuse' or 'drug misuse' pervade throughout both the formal and the grey literature. This leads to a confusion that has existed for as long as people have thought and written about drug use in any meaningful fashion, to try to describe and understand what is meant by the term 'addiction'.

This confusion is further exacerbated by such titles as *The Myth of Addiction, (Davies 1997)* where the author rejects the notion of addiction as something that *happens to* people, but rather explains those behaviours and outcomes that are usually associated with 'addiction' as the results of something that people *do.* The whole text is centred on Attribution Theory as a means of explaining why things happen, so in this context he argues that attribution theory is the reason for why people become 'addicted', as opposed to the purported 'addictiveness' of a substance or behaviour. This rationale is echoed within Schaler's text *Addiction is a choice (2000)* where the author argues that addiction is the result of choices that a person makes due to free will (something we do) as opposed to addiction being the result of a disease (something we have).

Zinberg *(1984)* goes further, and states that the effect of a drug is not necessarily the same universally amongst users. His text is based on the proposition that the effect of a drug is based on 3 variables – the drug itself, and how that drug affects the central nervous system (i.e. is it a stimulant, depressant, hallucinogen, analgesic, or a combination of more than one of these properties?); the mindset of the user at the time (i.e. is the user happy, sad, manic, depressed etc?); and the setting of the use (e.g. is the user alone, with friends, with people he doesn't know and feels wary of?). Also within the variable of 'setting', the user's general sense of self, living conditions and employment status makes a difference. A user who is employed, owns his own home and does not have financial issues would be in a very different setting to someone who is street homeless, for instance. It would follow therefore that we need to consider how addiction, however we define it, would affect a street homeless drug addict in comparison to a well-off company director drug addict. This ideology links to descriptors proposed by other authors who are interested in the harm drug use causes a user, more than just defining the psychotropic properties of a drug.

Following on from Zinberg, both Johann Hari *(2019)* and Gabor Maté *(2018)* write eloquently about the cause of addiction not being the addictive nature of the substance being used, but the circumstance that the user finds themselves in. Hari interviewed many people involved in the acquisition and ingestion of various substances for his book, and others who were interested in the pharmacology and psychology behind the use of substances, to try to understand why people use drugs. The most significant conversations were with Bruce Alexander, and the stories behind his, now famous, 'Rat Park' experiments in the late 1970s *(Gage and Sumnall 2018).* What Alexander and his colleagues discovered was that rats who

lived alone in a confined cage, with access to two water bottles, one containing just water and the other containing a sweetened Morphine cocktail, drank the morphine mix to their severe detriment. However, rats who lived in Rat Park, a larger cage with toys, other rats and plenty of space, took hardly any of the morphine mix, even though it was readily available. They deduced from this that the drug itself is not what causes the harmful behaviour, but the environment the rats find themselves in. Hari took this idea and from it posits the theory that what drives humans to use harmful substances is not the drug itself, but the lack of connectedness *(Hari 2019).*

Maté, like Hari, uses his own story as a conduit to writing about addiction, but for this section of the thesis I was most interested in his chapters on the scientific aspects of addiction. At the start of chapter 11 *(Maté 2018:127-128)* he gives a number of definitions of the word 'addiction' from throughout the ages, and notes that it originally meant "an activity that one was passionate about" *(ibid:127).* He goes on to note that it's only in the past 100 years or so that it has become to mean a dysfunctional dependence on a substance or a behaviour. Maté offers a 4-point table to describe his definition of addiction: -

1. Compulsive engagement with the behaviour, a preoccupation with it;
2. Impaired control over the behaviour;
3. Persistence or relapse, despite evidence of harm; and
4. Dissatisfaction, irritability or intense craving when the object – be it a drug, activity or other goal – is not available. *(ibid: 128 – 129)*

Maté goes on to declare that he thinks that "the addiction process is too multifaceted to be understood within any limited framework" *(ibid:130)* and so he makes no reference to the notion of 'disease' within his definition. He does acknowledge that the neurology of the individual under consideration is relevant, and so he views addiction as the result of personal history, emotional development and brain chemistry.

It seems clear then that both Hari and Maté view addiction as something that goes beyond the chemical composite of a substance that is being ingested, and agree that the personal circumstances of the 'addict' are much more important in trying to understand why that 'addict' would engage in 'addictive behaviour'.

Denning and Little *(2012)* write about Harm Reduction Psychotherapy, and within their text they argue against the binary idea that a person is either a substance user or not, and offer

a continuum of substance use that sets out the different levels that a person might use a substance, and the reasons for so doing. The different levels of use are described as follows: -

- Benign – the substance in question is not used at all.
- Experimentation – the substance in question is tried out of curiosity when it is available, but the person has very few exposures to the substance.
- Social / Recreational – the substance is used for its specific effect, but a pattern of use has not been established.
- Habituation – a pattern of use has been established, but no problems ensue.
  N.B. 'Problems' in this context relate to the biopsychosocial model of harm *(Engel 1977 & 1980; Miller et al 2013)* This links back to Zinberg's proposition about drug, set and setting outlined above.
- Abuse – use despite negative consequences.
- Dependence – Abuse + compulsion + relapse potential.
- Physiological dependence – There is clear evidence of tissue and cellular accommodation.
- Persistent addiction – a term coined by Peele in 1991, this term is used to describe people who, having developed an addiction, fail to change it significantly with resulting deterioration. *(Denning and Little, 2012: 58 – 59)*

At the time of their writing, Denning and Little note that this continuum was not acknowledged in earlier versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), but in the (then upcoming) DSM-5 the elements were apparently going to be addressed. This was indeed the case, as described below.

1.5.1 DSM and ICD

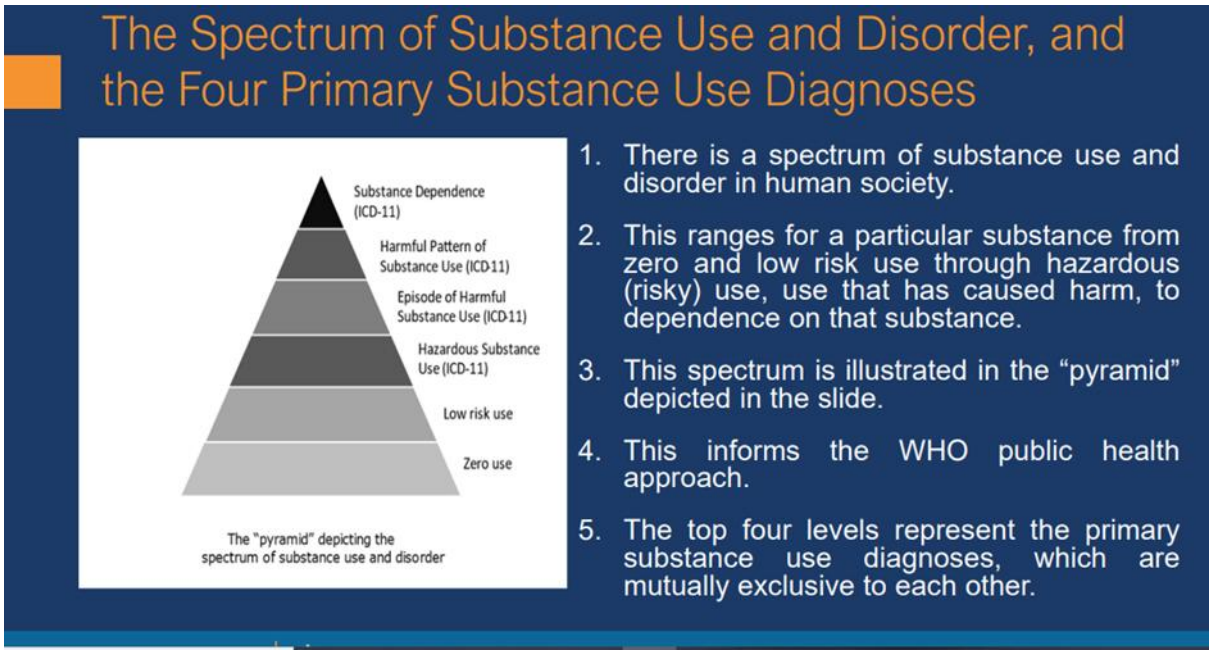
The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, is regarded as one of the main sources of definition for understanding symptoms of various mental health issues – the International Classification of Diseases (ICD), published by The World Health Organisation, is the other.

The DSM-5, published in 2013, describes "Substance Related Disorders", rather than 'Addictions', and defines these disorders thus: -

> "The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems". *(2013:483)*

The important central tenet of this disorder centres on the emphasis that there are symptoms of detriment to the person, yet this person carries on with this disordered behaviour despite these detriments. The ICD-11 was published in 2018, and this newest revision changed the way that Addiction and Substance Use Disorders were categorised. In 2021 John Saunders gave a presentation entitled *"Disorders due to Substance Use in ICD-11: diagnostic guidelines and key changes" (Saunders 2021)* to the Royal College of Psychiatrists Conference on the ICD-11 Mental and Behaviour Disorders, and utilised various diagrams and graphics to illustrate his talk. Within his presentation, Saunders describes the spectrum of substance use and disorder, and the four primary substance use diagnoses *(ibid)*. He represents this spectrum as a pyramid, as shown in figure 4 below.

Figure 4: The Spectrum of Substance Use Disorders, from ICD 11. (Taken from Saunders 2021)



The pyramid represents the level of risk to the user, relevant to each individual substance that the user may be engaged in using, ranging from no risk at the bottom to being dependant at the top. The pyramid is also representative of the level of use amongst society in general, in that many more people are at no risk from harm, as many fewer people use any

particular substance, compared to those that do not use it. Ergo, the 'zero use' category covers a much larger area of the pyramid than the very tip, which represents 'dependent use'.

Saunders then goes on to compare these descriptions with those from the DSM, to illustrate where the differences in definition occur. See Figure 5 below:

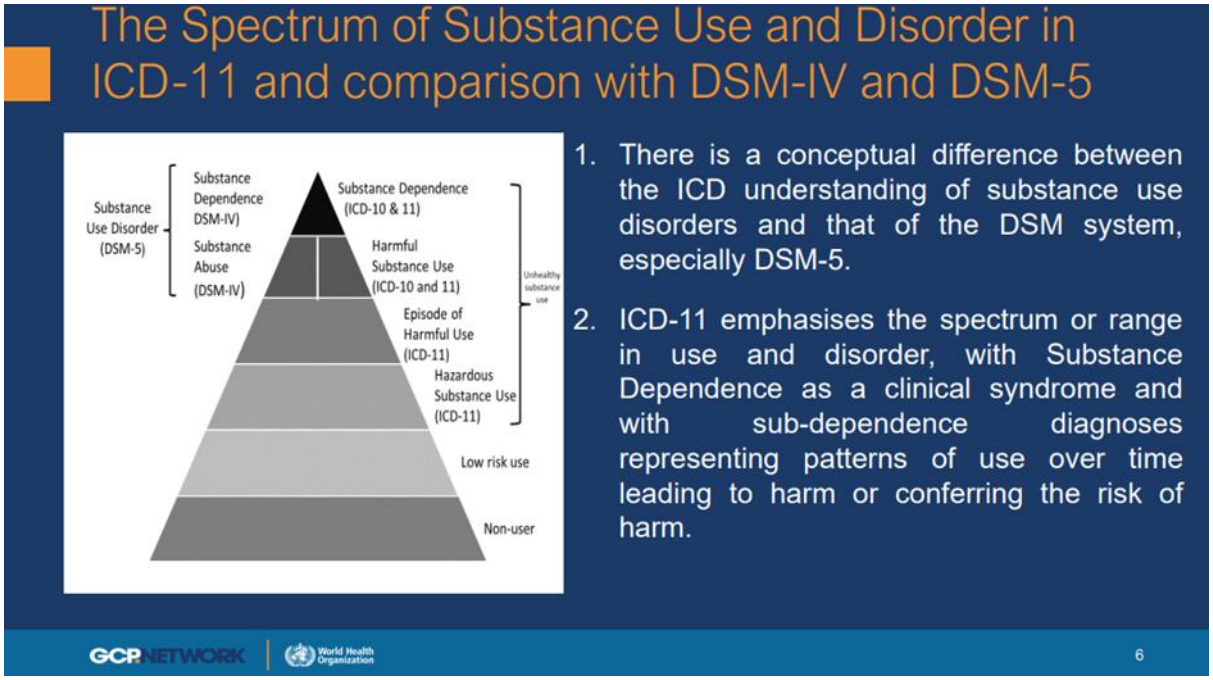


Figure 5: Comparing the Spectrum of Substance use Disorder in ICD 11 with DSM iv and DSM 5. Taken from Saunders (2021)

It can be seen that, according to Saunders' diagram, the top 2 segments of the pyramid correlate to the DSM-iv definition of Substance Abuse and Substance Dependence, which in turn are now amalgamated into one category in DSM-5, named 'Substance Use Disorder'.

Similarly, the top 2 segments were covered in the ICD -10 as Harmful Substance Use and Substance Dependence, whereas in ICD -11 2 new definitions of use are added to the hierarchy, giving the 4 Primary Substance Use Diagnoses that now appear within that volume.

This thesis does not require that I go into a fuller, wider definition of the various harms that are laid out within the ICD -11 and DSM-5, but it is pertinent to reproduce the definition of Substance Dependence, which is

> "a disorder of regulation of substance use arising from repeated or continuous use of that substance and consisting of a strong internal drive to use that substance" *(ibid)*

To bring this sub-chapter to a close, it seems pertinent to refer to the text that has had a huge impact on me whilst I have counselled, supervised, and taught within the addiction field. In *The Theory of Addiction (West and Brown, 2013)* the authors describe many varied definitions of addiction, and offer them under sub-headings to group these various ideas together. Within the first few pages of the text the authors offer a history of the word 'Addiction', and how it has appeared within the literature throughout time. They proceed to then describe the different ways that addiction has been defined from various standpoints, and also guide the reader toward their own definition of addiction, based on how the collated definitions influenced their thinking. It is this definition, and the authors' route towards it, that most interests me, as it is centred on the notion of motivation. My work as a counsellor within the addiction field, and subsequently as a supervisor of other counsellors, leads me to consider a person's motivation to use substances as most pertinent when considering treatment, over and above the type of substance used, or the method of ingestion etc. This ideology links back to the definition of Substance Use Disorders from the DSM 5 noted above, where the notion of the user continuing to use a substance even though they experience detriment is central to the definition offered. I consistently ask myself "What is the user's motivation to carry on using in the face of such detriment?"

The authors describe a synthetic theory of motivation, which they call 'PRIME Theory', which they state provides a basis for a theory of addiction. They state that PRIME Theory lies within a broader model of behaviour, known as the COM-B model, where for any behaviour (B) to occur, three conditions have to be present – Capability (C), Opportunity (O), and Motivation (M). This behavioural model has been known for many centuries, e.g., the authors cite the American legal system, where for an individual to be convicted of a crime (the Behaviour), the prosecution has to prove means (Capability), Motive and Opportunity *(ibid: 192).*

The authors explain that, to understand addiction, there is a need to understand the human motivational system, which they describe as

> "the system of brain processes that energise and direct our actions" *(ibid:194)*

The authors acknowledge that there are many theories of motivation, yet (at the time of their writing) none had sought to integrate them into one synthesised system, which is what they have set out to do with their PRIME model. 'PRIME' is an acronym, and the 5 letters relate to the five subsystems that make up this human motivational system. The authors present a graphic to illustrate how these subsystems interact with each other – see Figure 6 below – and they also provide brief descriptors of the meaning for each word within the acronym:

P = Plans – conscious mental representations of future actions plus commitment.
R = Responses – starting, stopping, or modifying actions.
I = Impulses / Inhibitory forces – can be consciously experienced as urges.
M = Motives – can be consciously experienced as desires.
E = Evaluations – evaluative beliefs. *(ibid: 195)*

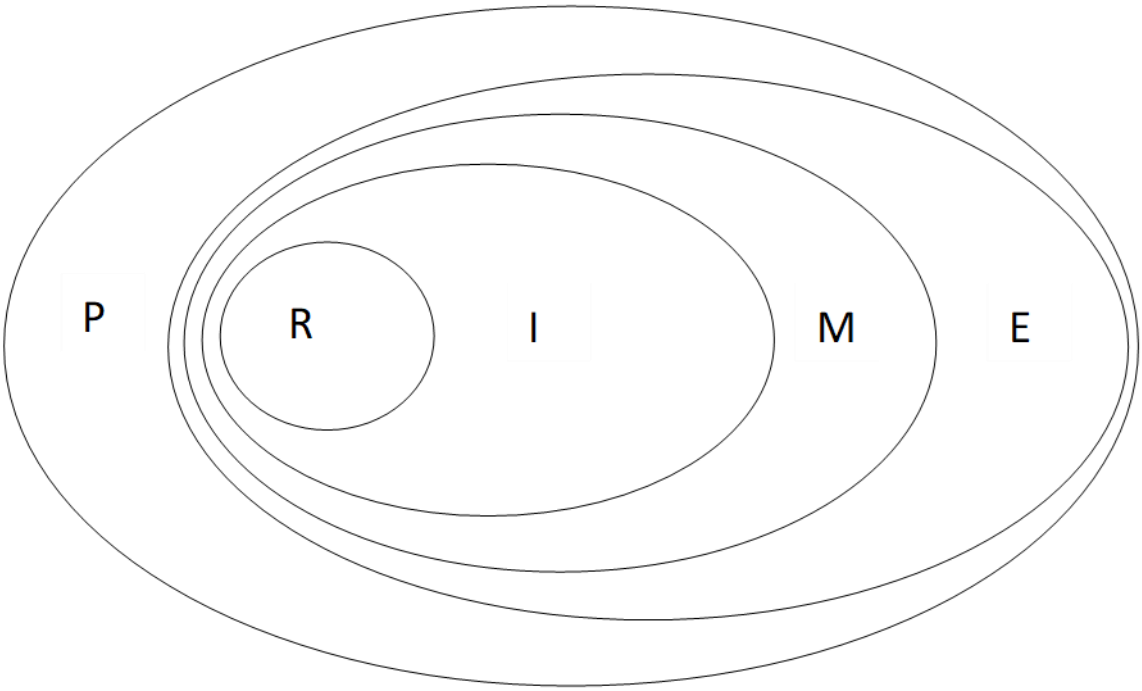


Figure 6: A Schematic of the five subsystems that make up the human motivational system. Taken from West and Brown (2013: 195)

To understand motivation, it is necessary to understand how the 5 sub-systems interact with each other, and, when considering addiction, the authors posit that any one of the sub-systems could be affected and function abnormally, which would constitute 'Addiction'.

The way that the different sub-systems are laid out within the graphic illustrates how these sub-systems influence each other. As an example, evaluations (E) can only exert influences on impulses (I) through motives (M), and similarly evaluations (E) can only influence responses (R) firstly through motives (M) and then through impulses (I). The authors state that plans provide a structure to human actions, and that plans influence those actions mainly via the evaluations that a person would make as they consider the action. The model suggests that there are stages of motivation, and it needs to be understood how these stages manifest for human motivation to be fully understood.

As well as the graphic for the Prime model, the authors also provide a graphic that illustrates how the sub-systems interact practically, and where the various elements of the motivation system exists anatomically within the human brain. This graphic is reproduced below as figure 7: -

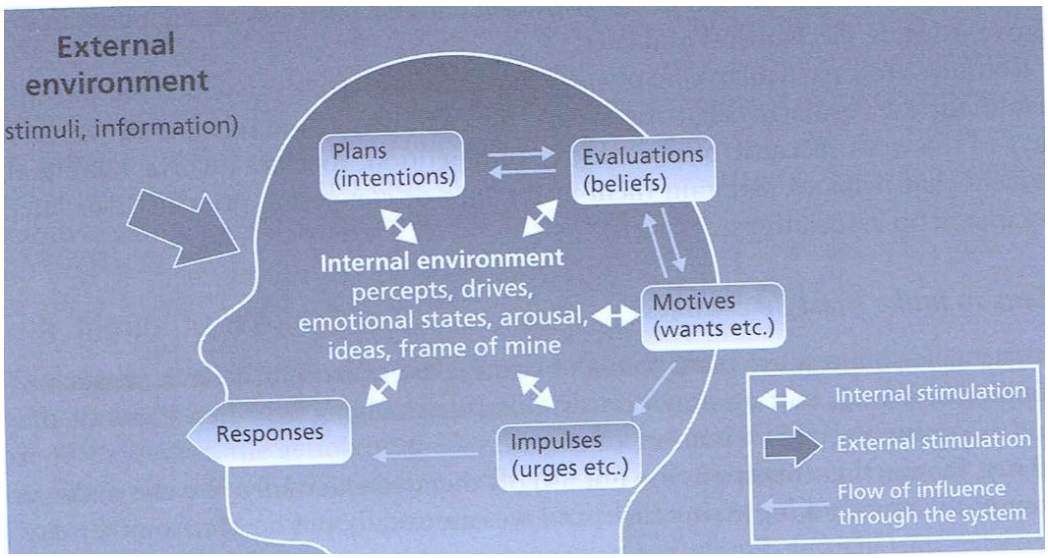


Figure 7: A Schematic of the 'head' model of the human motivational system. Taken from West and Brown (2013: 206)

The illustration is suggestive of a flow chart, where the various sub-systems can be seen to influence each other in a way that leads to a response to a stimulus, be that an internal stimulus or an external one. The positioning of the text within the graphic is also designed to indicate where within the structure of the brain the various subsystems reside – the planning system resides within the frontal cortex, as does the evaluation sub-system. The motive system is positioned across both the cortex and the mid-brain, whereas the impulse-inhibition system is wholly within the mid-brain area. 'Responses' is shown on the graphic as coming

out of the mouth, as the authors note that "much of human behaviour does involve a lot a talking" *(West and Brown 2013: 206)*.

If we therefore combine the information contained in figures 6 and 7, we can understand how the authors describe human motivation as a series of interconnected drives or impulses that influence each other in such a way as to lead to a behaviour.

This thesis does not require that a longer, fuller explanation of the theory is offered; it is sufficient to merely note that the pathway from the COM-B model of behaviour leads to the authors' PRIME theory of motivation, which in turn allows them to offer their own theory of addiction. They state that

> "Addiction is a social construct, not an object that can be uniquely defined…addiction can be usefully viewed as a chronic condition involving a repeated powerful motivation to engage in a rewarding behaviour, acquired as a result of engaging in that behaviour, that has significant potential for unintended harm" *(ibid: 229)*

This for me encapsulates what I have come to understand, empirically and academically, during my time working and studying within the field of addictions as an understandable, workable definition of what addiction is, and how it manifests. I do not believe that simple, definite statements, such as 'Addiction is a disease', or 'Addiction is the result of Free Will' fully explain the complexities of addiction as a series of thoughts, impulses and behaviours that result in the unintended harm that often occurs when a person engages in said behaviours.

West and Brown have collated the various ideas and theories that have informed them to devise their own theory of addiction, and it is to their theory of addiction that I shall henceforth be referring, within this thesis.

As a means of linking into the next sub-chapter, Kemp *(2009)* offers an interesting take on the subject of addiction when writing about addiction from a phenomenological perspective. His paper is centred on the notion of 'lived-time', or temporality, and the author is interested in exploring the relation of the addicted-subject to time *(ibid).* This paper is explored in more depth in the literature review below, in sub-chapter 2.3.9.

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