Perspectives on Addiction

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Abstract

Trying to provide a lucrative definition for addiction has been a source of frustrations for scientists ever since the beginning of the 20th century. Provided this fact, the present paper intends to offer a clear review of some of the main approaches to addiction, in order to help conceptualize cases when confronted within a specialists' practice. Such approaches include the dependency perspective, the psychiatric perspective and the psycho-dynamic perspective, as all such approaches provide the specialist with important components to support an addiction intervention.

Keywords: *addiction, dependency, substance use, theoretical perspectives*

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I. ADDICTION FROM A DEPENDENCY PERSPECTIVE

Trying to provide a lucrative definition for addiction has been a source of frustrations for scientists ever since the beginning of the 20th century. A first step was attempted by Himmelsbach who, in 1943, defined physical addiction as: "...an arbitrary term used to denote the presence of an acquired abnormal state wherein the regular administration of adequate amounts of a drug has, through previous prolonged use, become requisite to physiologic equilibrium. Since it is not yet possible to diagnose physical dependence objectively without withholding drugs, the sine qua non of physical dependence remains the demonstration of a characteristic abstinence syndrome" (Himmelsbach, 1943).

Taking into account all of Himmelsbach's insights into this field, Halbach, Isbell and Seevers have arrived, in 1965, at the following particular definition of physical dependence: "intense physical disturbances when the administration of a drug is suspended" (Eddy, Halbach, Isbell & Seevers, 1965). The same authors also felt the need to state that the behavioural aspect was in fact the essential element for diagnosing addiction, thus introducing the term of psychological dependence, tightly linked with the biological dependence, without being limited to that one. Here is how they explained it: the "drug produces 'a feeling of satisfaction and a psychic drive that require periodic or continuous administration of the drug to produce pleasure or to avoid discomfort'..." (Eddy, Halbach, Isbell, & Seevers, 1965).

Further definitions of dependence mainly highlighted the synthesis between the physical and the psychological aspects, bringing even more into light the influence of the psychological factors on the physical symptoms of withdrawal, emphasizing the role of the motivational aspects. Generally used in the drug field to refer to chronic, compulsive, or uncontrollable drug use, to the extent that a person (referred to as an 'addict') cannot or will not stop the use of some drugs. It usually implies a strong (Psychological) Dependence and (Physical) Dependence resulting in a Withdrawal Syndrome when use of the drug is stopped.

Many definitions place primary stress on psychological factors, such as loss of self-control and overpowering desires; i.e., addiction is any state in which one craves the use of a drug and uses it frequently. Others use the term as a synonym for physiological dependence; still others see it as a combination (of the two) (Nelson, Pearson, Sayers & Glynn, 1982).

The term that psychologists and psychiatrists are using now, Substance Use Disorder, could be defined as the troublesome pattern of drug use and abuse which leads to clinically significant dysfunctions, as reflected in at least two of the eleven criteria mentioned under the DSM V, for a period no shorter than 12 months.

II. ADDICTION FROM A PSYCHIATRIC PERSPECTIVE

Seen from a psychiatric point of view, drug addiction shares aspects referring to both impulse control disorders and to compulsivity disorders (Brady, Myrick, & McElroy, 1998). Impulse control disorders are characterised by the excitation or tension which reaches high levels between indulging into an impulsive behaviour, accompanied then by a feeling of satisfaction, pleasure, gratification or alleviation right after indulging in the act, only to be followed by regret, self-blaming and repentance, dissatisfaction and remorse when enough time has passed.

By contrast, the compulsive disorders are characterised by a sense of anxiety and stress before acting upon the urge to behave in compulsive, repetitive manner, followed by satisfaction and by relief, liberation from stress right after the compulsion was acted upon (Grant, & Potenza, 2006). Typically, an individual may evolve from an impulse control disorder to a compulsion disorder by means of positive reinforcements used and overused up to the point where they become negative reinforcement behaviours. It has to be noted that both positive and negative reinforcement behaviours have the potential of motivating a certain type of behaviour.

Drug addiction has a gradual progression, from impulse to compulsion, in a three-phase cycle: it starts with preoccupation/anticipation, goes into binging/intoxication, and ends in withdrawal/ negative affects (Kaufman, 1994). The cycle does not stop here, since the negative affects can be muted with another dose of the drug, which brings around an entire new succession of the three stages.

III. ADDICTION FROM A PSYCHO-DYNAMIC PERSPECTIVE

The first to formulate a psycho-dynamic perspective on addiction, integrating neurobiology aspects, was Khantzian who, together with his collaborators, tried to highlight the factors which bring about vulnerability to addiction (2007). Their point of view is deeply rooted in the psycho-dynamic aspects of clinical practice, where the main issues that are to be taken into account are the developmental difficulties, emotional or affective disturbances, structural (or ego) aspects, as well as the manner in which the personality is constructed and what the "self" and the way this was built represents for the individual.

Researchers were able to identify two critical elements (disorganised affects and flawed self-care hygiene), as well as two contributing elements (impaired self-esteem and disorganised social relationships). All of these have been brought together in order to posit a hypothesis referring to self-medication, which states that individuals suffering from Substance Use Disorders are indeed using drugs as a coping mechanism, helping them to manage emotions which they perceive as being painful and menacing and would therefore like to avoid for as much

and as long as possible (McKay, & Fanning, 2005). In the framework of this conceptualisation, addicted individuals feel subjective levels of distress and of suffering, which may or may not meet the criteria for a psychiatric disorder, as per the provisions of DSM-5 (2013).

Individuals affected by an addiction feel that their emotions are overwhelming and impossible to manage or to handle, while their affective life is either lacking or is very hard to define. Seen from this point of view, drug addiction can be considered to be an attempt at self-medication of the disorganised affective life (Khantzian, & Albanese, 2008). The client who has fallen victim to addiction is profoundly overwhelmed by disordered affects, characterized, when they reach the extremes, by an unbearably painful emotion and by a feeling of inner emptiness which gives way to profound distress. Others, also affected by addiction, have difficulties in expressing their feeling or even in accessing their emotions, as they may suffer from Alexithymia (Taylor, Bagby, & Parker, 1999).

Self-medication might be very specific, since each class of drug can be used as an antidote or as a replacement for deficit at the level of the individual's psychological structure. Paradoxically though, using non-prescription drugs in order to self-medicate emotional pain may well have the exact opposite effect, perpetuating the negative effect in the first place, while also driving the user towards a more and more isolating life style which is focused around drug use – preoccupation with buying it, obtaining it, using it, hiding its effects etc.

The lacking of the proper skills to take care of one's self is nothing but a mirror of the inability to guarantee one's own survival, being therefore characterised by the incapacity of anticipating or of avoiding dangerous or unstable, perilous situations, as well as by the inability of using one's own reasoning and emotions as a guide meant to help one deal with disadvantageous contingencies (Lumley, Neely, & Burger, 2007).

We may therefore state that the difficulty felt by one when trying to take care of one mirrors or foreshadows the inability to properly manage emotions and to recognize the consequences of deviant behaviours. The main element of this psycho-dynamic view upon addiction is the disorganised emotional system of the individuals which makes them prone to addictions.

Here are they typical defence mechanisms of the ego used (or rather, misused) by those affected by a Substance Use Disorder (Thombs, 2013):

1. Compensation: it replaces the deprivation felt during the abstinence phase of the addiction cycle by over-saturation, overindulgence in another pleasure or amusement (e.g. an ex cocaine addict may turn to gambling as a way of replacing his old pleasure-bringing addiction with a new one).

2. Denial – the inability to perceive and accept a reality which does not support one's one view of life. This is the case of the alcoholic who denies having a drinking problem, even when

faced with the bottle of liquor hidden in his office desk, or the marijuana user denying that it was his use of the drug that made him miss important appointments during the week.

3. Displacement – the hostility which has been racked up throughout time because of the uncomfortable context of one's own life becomes directed towards people who pose a smaller threat than those who served to create the negative feelings in the first place.

4. Fantasy: individuals find gratification and satisfaction despite the objective loss they are experiencing by imagining or remembering the euphoria and the exhilaration of a past abuse.

5. Isolation: the individual withdraws into a state of passivity, hoping thus to avoid being hurt again in the future. It is seldom that addicts will deny having any problems and will refuse to talk about anything that could constitute an obstacle, since, in their view, that would lead to nothing good.

6. Projection: the individual is convinced that the others also have bad sentiments towards him, not paying any attention to the fact that this displeasure has never been communicated. (E.g.: „I know you think I'm just a good-for-nothing, a lazy-no-count.")

7. Rationalization: the afflicted individual is trying to justify one's own failures or transgressions by presenting rationales and possible explanations for his or her behaviour, motives "forcing" him to act in a certain way.

8. Regression: the individual chooses retreating to an earlier developmental stage, which involved less mature responses than the ones required of him/her in the present.

IV. CONCLUSIONS

This psycho-dynamic take on addiction is optimally integrated with the neurologic approach on addiction, stipulating the critical role played, in the addiction mechanism, by the reward system and by the stress regulation system, which both can be found at the cerebral level and both showing deficiencies in the case of addicted individuals. From a neurobiological perspective, the personality of the addict, already vulnerable, is further affected by the direct effect of the drugs, which thus serves to continue and encourage the vulnerability circle, enhancing its impact (Straussner, Spence, & Dinitto, 2014).

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