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Switching to a Social Approach to Addiction: Implications for Theory and Practice

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Abstract The concept of addiction is complex and shaped by a range of understandings including how the recipient of an addiction is interpreted. This paper examines how concepts of self and concepts of addiction interact. Two fundamentally different understandings of self are considered: one which focuses on the self as a bio-psychological individual, the 'particle' self, and another that focuses on the self as a nexus of relationships, the 'social' self. The effect these have on understandings of addiction is examined along with implications for service interventions. Particle-informed understandings of addiction are seen as dominating services and leading to intervention responses that focus on the individual and de-emphasize the role of family, community and culture. The absence of social understandings limits both the range and quality of services offered. Particle and social approaches to addiction could operate side-by-side in offering a broader range of effective service responses to addiction.

Keywords Family inclusion · Social approach · Bio-medical approach · Community engagement · Treatment interventions

Marianne Valverde (1998) in her book *Diseases of the Will* tracks the evolution of current conceptions of addiction from their origins in the nineteenth century where psychological notions of 'will' and 'habit' jostled with more biological constructs such as 'disease' and 'dependence'. By the mid-twentieth century, debate between these two alternatives was settled through the rising influence of the American Psychiatric Association and the World Health Organization. The concept of 'dependence' prevailed and with it came a preoccupation with bio-medical brain processes and genetics. This emphasis on biological processes has persisted through into current times (Hyman 2005; Robinson and Berridge 2002). Nonetheless, during second half of the twentieth century the dramatic rise of the discipline of psychology opened up a broad range of new ways of relating psychological processes to addictive behavior. For

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example, learning theory, with its roots in operant behaviorism, shifted the focus on addiction from biology to behavior followed later by a shift to cognitive processes as manifest in beliefs, emotions, motives and attributions (Heather 1998; Weiner 1986). Theories of addiction were able to draw on explanatory concepts such as 'conditioned responses', 'reinforcement contingencies', 'cue exposures' and 'motivational enhancement' (Carroll and Onken 2005; Marlatt and Donovan 2005; Rubak et al. 2005).

Current theories of addiction draw by-and-large on interpretations of 'self' as a complex of biological, behavioral and mental processes (Blume 2005; DiClemente 2005). This clearly locates addiction as something that is primarily occurring at the level of a discrete individual. The current paper concurs with others who have criticized the reduction of the addicted self to a discrete individual and argued in favor of a more social interpretation (Alexander 2012; Granfield 2004). It proposes a flip in perspective, a paradigm shift, whereby addiction is seen less as an attribute confined to an individual person and more as a social event.

The Particle Self

A common way of thinking about 'self' is to see it primarily as an individual object and that this object—or particle—is the appropriate focal point for understanding addictive processes (Elster and Skog 1999; Robinson and Berridge 2002).

Indeed, there are several ways I can view myself as a particle. I am certainly a biological particle: I am made up of bones and muscle, fluids and organs, neural networks and hormonal systems. These are all bound together within a fleshy container; that skin membrane that holds me together as a separate organism from others around me. I am also a psychological particle: I experience thoughts and memories, emotions and motivations, attitudes and heartfelt beliefs. These cascade through my consciousness and add together in comprising my inner world; they belong to me and only me and are separate from the psychological events that others may be experiencing. Together these two aspects—myself as a body and myself as a mind—converge and hold me together as a discrete individual—as a particle.

Moreover I can project this particle thinking onto other people. I can see them also as discrete autonomous units, self-contained objects with distinct bodies and minds, moving about within a shared environment in which they connect and disconnect much like balls bouncing off each other across a billiard table. I can also make sense of their behavior through my knowledge of the attributes which are contained and travel about inside them as objects. Similar to the way I judge the movement of a ball by attributes such as mass, inertia and angle of movement, so I make judgments of the behavior of other people based on my knowledge of contained attributes such as intelligence and character, beliefs and motivations.

What both the body-particle (bio-medical) and mind-particle (psychological) interpretations have in common is a thorough commitment to the site of addiction as residing firmly with this autonomous individualized self. Accordingly, treatment services have few qualms in focusing most their efforts on people as discrete entities. People commonly travel alone to be assessed at outpatient clinics, they are admitted alone into residential programs, they receive counseling in isolated offices and, where possible, their body-particles are assisted with medications. Very little attempt is made to engage their social contexts; the addiction is firmly located with the individual, not anywhere else.

The Social Self

A growing body of literature in the social sciences have challenged theoretical frameworks which reduce understandings of the self to a singular particle (Depelteau 2008; Fergus and Zimmerman 2005; Gergen 2009; Wilson 1997). Drawing on a variety of academic traditions, including critical sociology and social ecological theory, a social frame involves a radical shift in focus from viewing the self as primarily a discrete particle to viewing it more as an intersection point situated within a complex web of relationships (Graham et al. 2008; Larkin et al. 2006). In this way addiction is seen less as a psycho-emotional event and more as a social event.

To illustrate this, consider the plight of a film crew parachuting into an unfamiliar culture where, through an interpreter, the first question the interviewer is asked is, "Who are you?" This is a tricky question particularly when the two parties have little in common. The interviewer could respond by reflecting on herself as a particle, "Well, physically I'm tall and strong, and good looking … and as a person I am kind and thoughtful and highly motivated in my work…" Her description tapers off as she struggles to think of relevant features. She decides to switch from talking about attributes to describing relationships, "Well, I'm a mother with a 2 year-old child, my parents live next door, I work on contract for 6 months per year, I am studying computing at night school…" It is likely her hosts will find the second description of family, social and occupational involvements easier to relate to because they too participate in similar relationships.

In a similar fashion, when considering personal identity I have the option of viewing who I am in terms of attached qualities or attributes, or, alternatively, I could switch to looking at myself in terms of relationships: I am married, I am the father of four children, I am employed at a university, I play tennis and so on. This 'I', this 'I-place' I continuously occupy is positioned at the center of a radiating network of meaningful connections that provide the substance for how I construct an image of myself. Each connection is dynamic: I put energy into them and receive energy back. Sometimes the connections are strong and positive, at other times they are weak and troubling; some connections may fade altogether and be replaced by new ones.

In a social frame, addiction is positioned within this nexus of meaningful connections. The addicted self is seen as entering into an intense relationship with the object of the addiction—such as alcohol, heroin or gambling—to the detriment of other relationships within that social network. As this relationship intensifies, the excessive preoccupation with one object consumes time and resources at the expense of other surrounding relationships. For example, a heavy investment in drinking may result in diminished input into a marriage which leads onto marital conflict which may then encourage further strengthening of the addictive relationship resulting in problems with other relationship such as with friends or workmates. This pattern of strengthening one central relationship at the cost of surrounding relationships enables the addictive social system to emerge. Relationships within this system become overshadowed by this one rigid dominant connection, a central axis between the person and the addictive object. Other relationships are secondary relationships; their status is negotiated and mediated via this central axis.

A social interpretation of addiction offers up a different way of looking at treatment interventions. Just as the strengthening of an addictive relationship is linked to the degradation of other relationships, so any weakening of the addictive relationship requires a process of gradually strengthening other relationships. The addicted self is unlikely to relinquish its

attachment to the addictive object unless alternative relationships have strengthened or look like strengthening. Accordingly, service interventions need to focus on activating the opportunities for quality relationships within what remains in that social system (Copello and Orford 2002; Simmons 2006). For instance, Selbekk et al. (2014) examined two social models of addiction (including the model described here) for use in addiction services. They highlighted how the process of change is, by necessity, a slow process which focuses primarily on the immediate caring relationships of friends and family.

Problems with Particles

Proponents of strictly particle understandings of addiction—of both a bio-medical and psychological persuasion—face a range of problems. While remaining firmly invested in explanations founded at the level of the individual, over the last 40 years it was becoming increasingly clear that social factors do play quite a significant role in both the origins and course of most addictions. This challenges the dominance of particle assumptions and calls for some form of accommodation to protect this way of thinking from other alternatives.

The crucial role social factors play in addiction emerged from several directions at roughly the same time. From one direction, aspects of the social situation seemed to be playing a larger role than expected. For instance, many US soldiers who had become addicted to opiates during the Vietnam War were returning home and managing without assistance to resume their previous non-addicted lifestyles (Keane 2002; Robins 1993). Publications by social scientists were revealing the highly influential role social and community context plays in relationships to alcohol and drug use (Courtwright 2009; MacAndrew and Edgerton 1969; Einstein 1980; MacAndrew and Zinberg 1984). Elsewhere health researchers were uncovering the potent role social determinants—such as relative deprivation and social marginalization—played in health and wellbeing, including its interactions with addictive behavior (Buchman et al. 2011; Galea and Vlahov 2002; Wilkinson and Marmot 2003;). Some theorists have even challenged the whole construction of addiction as a discrete entity (Davies 1992; Keane 2002). From another direction, cultural circumstances appeared to be playing more of a role than previously thought (Heath 2000; Marshall 1979; Orford 2013). For example, the tragically high rates of addiction in colonized indigenous populations made little sense using particle explanations. Making sense of it clearly required explanations that draw on understandings of the social dynamics of cultural oppression and alienation (Brady 2000; Wilkes et al. 2010).

Particle-based research efforts were also running into problems. Body-particle and mind-particle research endeavors had for many decades claimed the bulk of available research funding. For example, Loraine Midanik (2006) has provided detailed analysis of the way investment in alcohol research in the United States had become dominated by biomedical approaches. Interestingly, despite the lack of investment in social research, many of the most promising treatment interventions are those that include social aspects such as family inclusion or community engagement (Klostermann and O'Farrell 2013; McCrady et al. 2006; Miller and Wilbourne 2002). Midanik and others (Cunningham and McCambridge 2012; Kalant 2010; Midanik 2010) have questioned whether this strong commitment of resources into researching particle approaches is producing sufficient dividends. They ask whether an equal commitment to research in both particle and social frames would be more fruitful in making a real difference with addiction.

In order to accommodate these social influences while protecting investment in a particle frame, talk in addiction theory moved away from strictly bio-psychological interpretations and towards what became known as 'bio-psycho-social' approaches. Explanations could not be contained adequately within the bounds of the particle, and vague references to environmental influences no longer sufficed. The social world needed to be there and the bio-psycho-social frame recognized the complex and multi-leveled nature of addictions. The addition of the word 'social' enables addiction theorists to incorporate social dimensions into explanations and responses to addictions (DiClemente 2005; Engel 1992; Leshner 1997; Marlatt and VandenBos 1997).

However, social dimensions are not so easily reduced to 'variables', 'factors' and 'influences' attached to individual particles. Bio-psycho-social approaches do not embrace a truly social understanding of addiction. They tend to condense social dimensions into mere appendages attached to the primary particle. A person's social world—family and friends as well as occupational community involvements—are abstracted from their contexts and simply hung onto the particle as attachments. This enables treatment services to continue their work with particles while acknowledging the influence of social factors; individual clients report on their social and occupational involvements but family and friends are often firmly shut out of proceedings (Gergen 2009; Lee et al. 2012).

Applications

The book *Fragmented Intimacy: Addiction in a Social World* provides a detailed account of the broad range of alternative approaches that a social frame opens up for responding to addictions (Adams 2008). These approaches share a common interest in re-focusing attention away from isolated individuals and towards addiction as it occurs within social contexts. The following briefly outlines five examples:

Family inclusive practice

Services that seek to engage families recognize that changing addictive relationships is more likely to take decades rather than months or years. At the center of this whole process, and bearing the brunt of its vagaries, is the circle of people who care for that person—flat mates, neighbors, friends and family members. Accordingly, it is the complex of intimate relationships which should be seen as the powerhouse for long term change. Previously, family members have tended to be approached either as particles needing help in their own right or as a means of getting the addicted particle into treatment (Copello et al. 2005). Family inclusive practice widens the focus for intervention from the addicted particle to the family itself. It is, therefore, vital that right from the start therapeutic engagement occurs with the family and not with individuals because changes in relationships will ultimately determine the process of change. This re-orientation of services has been formalized into a number of intervention models including behavioral couples therapy (McCrady and Epstein 1995) and social behavior and network therapy (Copello et al. 2006).

Program transitions

A challenge for many particle interventions, particularly those that remove a person from their home environment for any length of time—as with residential or prison programs—is finding ways of reintegrating back into everyday life. For example, a

man attending a 3-month residential program may achieve a number of significant personal changes while in the program but, on discharge, he may struggle to maintain these changes in his normal social world. Indeed, the changes themselves may contrast negatively with the lack of change in his home environment. Residential treatment programs are increasingly recognizing the role social context plays in longer term outcomes (Dobkin et al. 2002) and many are actively pursuing ways to engage family members either during the course of the program or as a part of aftercare (Coletti 2010; Fernandez et al. 2006).

Peer social support networks

Another option for intervention programs is to set up systems that facilitate the formation of social networks on discharge (Boisvert et al. 2008; White et al. 2012). For example, clients discharged from the 4-week residential program at the Donwood in Toronto Canada were from 1986 invited to join in weekly groups run by volunteers, many of whom had graduated previously from the program. Since people were encouraged to attend for up to 2 years and with family member involvement also encouraged, a wide peer network soon formed that provided graduates and family members with an ongoing source of guidance and support. This and other types of peer networks provide another illustration of how particle and social interventions can function side-by-side and complement each other in terms of effectiveness.

Croatian/Italian 'clubs'

A 'club' is conceived of as an autonomous network embedded in a neighborhood with the primary purpose of assisting families affected by addiction in achieving abstinence and restoring quality relationships within a family. At the core of each club are two features: educational sessions, in which families are introduced to the nature of addiction and the principles of the clubs, and weekly meetings attended by family members including the person in the addictive relationship (Hudolin et al. 2001). The accent in the meetings is on families supporting families in establishing long term change. Club philosophy fully embraces a social interpretation of addictions that views any weakening of the addictive relationship as a function of the strengthening of other intimate relationships. From its founding by Vladimir Hüdolin in Croatia during the 1960s to its spread into Italy during the 1980s, the club movement has spawned to the formation of over four thousand clubs, with others emerging in several other European countries (Curzio et al. 2012).

Indigenous based approaches

For many traditional indigenous communities, connectedness to family, to one's village, to one's tribe, to the land and to a spiritual presence is understood as critical to health and well-being (Durie 2001). Addictive relationships cut deeply across these connections and in the process compromise the capacity of these communities to respond to the impacts of colonization, poverty and cultural alienation. Many indigenous populations struggle to engage with particle-based interventions offered in mainstream services and instead have embarked on setting up their own services based on principles derived from their social and cultural contexts (Huriwai 2002). These approaches draw on traditional kin and tribal relationships and incorporate traditional practices associated with healing and strength building (Lavallee and Poole 2010).

Implications

These examples illustrate how viewing addiction as a social event can form the base for a variety of innovative approaches to intervention. This does not mean social approaches are inherently superior to particle approaches nor that one should replace the other. The two frames involve different constructions of the addicted self and, accordingly, recommend different ways for services to operate. The differences in themselves are not a concern. What is problematic is the extent to which particle thinking has come to dominate most research, teaching and service environments. Its dominance has provided little room in which social approaches might establish their potential to contribute.

In the first instance social approaches may require some separation from particle approaches in order to develop their integrity and establish their credentials. But there could come a time when social approaches are sufficiently established to function in their own right without being interpreted and evaluated according to criteria derived from particle assumptions. Then the two approaches could operate side-by-side rather like the structure of a double helix where two separate but complementary strands spiral around each other, each strong grounded in its own assumptions and connecting with each other as the need arises. For example, in opiate substitution services, the particle strand would underpin the quality of pharmaco-therapy, case management, counseling and behavioral strategies and the social strand would underpin family engagement, cultural approaches, community engagement and other contextual needs such as employment and housing.

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