Vulnerability to addiction

PERSONALITY FACTORS

It is believed that an addictive personality exists which makes people more susceptible to addiction, suggesting that character defects exist in the individual, it also implies that it is inevitable some people will become addicted to some behaviour or activity because of a personality fault. Low self-esteem makes people more vulnerable to addiction.

Eysenck proposed the psychological resource model suggesting that an individual develops an addictive habit to fulfill a certain purpose related to the personality type of the individual. Eysenck said there are 3 personality dimensions, which are passed on genetically: P (psychoticism) includes aggression, coldness, impulsivity; N (neuroticism) involves moodiness, irritability and anxiety, E (extraversion) involving sociability, liveliness and optimism.

Bellin et al placed rats in a device where they could self-administer themselves cocaine. One group were the ‘sensation seekers’ who began with large doses but ultimately stopped, the other group were the impulsive rats who started on small doses but ultimately became addicted to the substance. Supports personality trait explanations to the substance is a greater risk factor.

Francis found supporting evidence for Eysenck, there’s a link between dependence on alcohol, heroin, BZs, nicotine and higher-than-normal scores in N and P traits. So, people who are more moody, irritable and anxious (high N) and those who are more impulsive and aggressive (high P) are more likely to become dependent on a drug or another addictive habit.

Support for low self-esteem leading to vulnerability comes from Chein et al, found that low self-esteem, learned incompetence, history of dependent relationships characterised what an adolescent addict. This supports the view that a negative outlook on life leads to individuals being more vulnerable.

Personality explanations are reductionist by over simplifying vulnerability to addiction, as being a result of certain traits such as impulsiveness or low self-esteem, in reality these factors may have to work in conjunction with other factors like socio-economic background, peers, and cultural factors. Vulnerability is so complex and researchers like Eysenck.
Evaluation

- CBT: Feeney et al reported 14% abstention rates in a group who had received CBT alone compared with 38% in a group who had received both CBT and medication → perhaps CBT works better in conjunction with drug therapy.
- CBT may only be effective when participants are able to engage with the therapist, those suffering from withdrawal symptoms for substance addiction may have difficulty with concentration and will not get anything out of CBT, so this is why drugs may be good to get rid of withdrawal symptoms and get the most out of CBT.
- CBT: Ladouceur et al showed that CBT can be effective in treating addictive behaviour like gambling. 66 pathological gamblers placed in either CBT or control group → Out of those who completed the CBT programme, 86% of them no longer met the DSM criteria which diagnosed them as pathological gamblers → reported better self-efficacy and self-control also.
- CBT: deals with the root cause → addictive people report low self-esteem, confidence and lacking problem solving skills which trigger the addiction → CBT tackles these and so has long lasting effects.
- Sylvain et al found similar results to Ladouceur et al, except they combined social skills training and relapse training to CBT → followed participants up after 1 year and results had no changed, showing that CBT has got long-term gains.
- MI: Dunn et al found that MI was effective in helping clients with substance addictions, especially as a means of encouraging them to progress on to more intensive treatment programmes.
- MI: Burke et al found that MI led to a 56% reduction in alcohol in the people who had been offered this treatment program.
- Aversion therapy: results have not been consistent across studies with regards to its effectiveness, aversion therapy focuses on the act of smoking not the tackling the underlying addiction.
- Aversion therapy has been criticised on obvious ethical grounds + has limitations (above).
- Aversion therapy: Meyer et al found it to be effective with 50% of alcoholics abstaining for at least a year following treatment → HOWEVER, this also shows that the treatment was short term.
- Smith et al found that ELECTRICAL aversion therapy was more effective than counseling methods illustrated above for about 6 months, however, the gains were not maintained.
- Aversion therapy: reason why it’s short term could be because aversion therapy does not target the cause or underlying addiction, simply the act instead → since some psychological therapies like aversion therapy just get rid of the behaviour, the individual may develop an addictive behaviour to another substance. Griffiths found that when some gambling addicts were treating with aversion therapy they developed another addiction after getting rid of the gambling addiction.
- Issue of psychological interventions is that they are costly + time consuming, so they’re obviously not suitable for everyone. Also, they may not be suitable for individual who’s personality makes them irresistible to change.

Biological therapies

Biological interventions are based on the assumption that addiction is a disease and usually involves medication. The goal of biological therapies is to aim for total or abstinence. It is inevitable individuals will experience withdrawal symptoms (severe ones include seizures and delirium) especially in the case of alcohol and illegal drugs. (note: opiate addiction refers to those addicted to drugs like heroin, morphine, etc.)

Nicotine replacement therapy (NRT)
This aims to treat smoking addiction by providing individuals with nicotine gum, patches and nasal sprays, which mimic or replace the effects of nicotine derived from tobacco. They relieve withdrawal symptoms (even in low doses), provide positive reinforcement due to their arousal and stress-relieving effects. These products allow smokers to self-administer nicotine whenever they get the urge to smoke (nicotine patches do not provide positive reinforcement, they allow for sustained nicotine levels all day) → they desensitize nicotine receptors in the rain, so individuals will find cigarettes less satisfying and will eventually drop it.

Nicotine vaccines
This leads to acute immunization so individuals develop antibodies to nicotine. The antibody binds to nicotine and slows down its entry into the brain, thus reducing its reinforcing effects of cigarette smoking. It’s effectiveness has not yet been proven.

Methadone
Methadone is administered orally to prevent withdrawal symptoms, block the effects of illicit opiate use and decrease craving. By taking methadone addicts can engage more readily in counseling and programmes like CBT. Methadone is an agonist which allows for a less harmful replacement for the dependent drug until the addict is fully withdraw from the real drug.

Bupropion
This is an antidepressant, which is also used to treat smoking. It works by increasing the levels of dopamine & norepinephrine, which simulate the effects of nicotine on these neurotransmitters. One way in which this tackles smoking addiction is similar to NRT, it blocks nicotine receptors and thus, reduces the positive reinforcement from a cigarette in the case of lapse.

Varenicline
This drug causes dopamine release in the brain → blocks the effects of any nicotine added to the system. It is a far more superior drug to bupropion in helping stop people smoking. This is an agonist drug.

Narcotic antagonist (naltrexone) treatment
Usually given to opiate addicts. The treatment begins after detoxification (removing toxic substances from body). A range of studies across cultures has found that detoxification is crap and relapse is common unless a rehabilitation programme comes into play. Naltrexone is a long-acting synthetic opiate antagonist → acts by blocking effects of self-administered opiates like euphoria → repeated lack of desired opiate effects breaks the drug habit.