

---

---

---

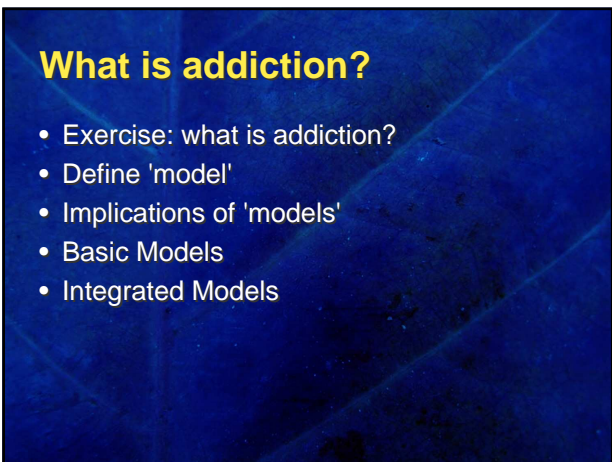
---

---

---

---

---



---

---

---

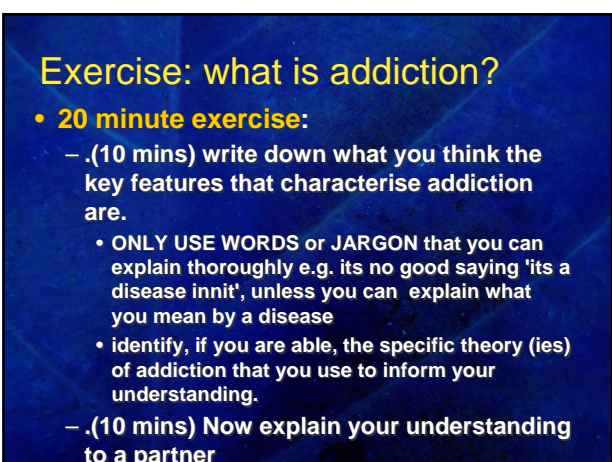
---

---

---

---

---



---

---

---

---

---

---

---

---

## Define 'model'

- “any representation of one phenomenon by another” (Jary and Jary, 2000)
  - E.g. addiction is a complex, subjective, lived experience, and a model seeks to simplify and explain in words.
  - Sometimes interchangeable with ‘theory’

---

---

---

---

---

---

---

---

## Implications of 'models'

- **'etiology'** (how it comes to be/works/is caused)
- **epistemology** (what is important to pay attention to)
  - Tell us how to produce 'valid' evidence, and what is 'not' valid evidence
- **ontology** (how it all works!!!)
- **They offer 'effective' treatment approaches**
- **Obviously the treatment approach must fit with the theory of the model...** if it is neurochemical then chemicals offer a treatment; if it is social then it is within 'society' that the appropriate treatment lies
- **Tension/conflict**

---

---

---

---

---

---

---

---

## Implications of 'models'

- **There are many models!!!**
  - (see West, 2001)
- Basic models and integrated models
- Some important questions
  - What does this model say about the client?
  - What does this model say about me?
  - What does this model say about our relationship?
  - What does this model include?
  - What does this model exclude?

---

---

---

---

---

---

---

---

## Basic Models

- **Moral Model**

- Moral weakness, lack of willpower, evil.
- Spiritual/religious overtones AND social
- Increase will power through religious conversion / punishment
- Benefits: moral inventory; personal responsibility
- Disadv.: Blaming, punishing

---

---

---

---

---

---

---

---

## Basic Models

- **Rational Choice Theory** (see Vuchinich & Heather, 2003; Skog, 2000)

- Substance use is an active, uncoerced choice. May be based on faulty information. Cost/benefit analysis
- Inform correctly. Increase costs (punishment), decrease benefits
- Benefits: empowers individual; avoids moralising; drugs become 'goods'
- Disadv.: Too simplistic; denies compulsion; can lead to 'punishment'

---

---

---

---

---

---

---

---

## Basic Models

- **Behavioural/cognitive behavioural (Learning)** (Marlatt & Gordon, 1985; Beck, 1993; WHO, 2004)

- Learned behaviour; conditioned responses; positive & negative reinforcers
- New learning; reconditioned responses; cognitive restructuring
- Benefits: non-judgemental; emphasis on learning; self-responsibility
- Disadv.: emphasis on control and control loss; can lead to 'punishment'

---

---

---

---

---

---

---

---

## Basic Models

- **Disease Model**

- Idiopathic (arising in the self); biological / genetic factors
- Abstinence; primary focus on the chemical dependency
- Benefits: widely supported; non-punitive; self-care not self-control
- Disadv.: can fail to recognise co-occurring independent disorders

---

---

---

---

---

---

---

---

## Basic Models

- **Self-Medication (psychodynamic/analytic)**

(Khantzian, 1997)

- Symptom of another primary disorder
- Improved mental functioning (therapy / counselling / pharmacotherapy)
- Benefits: non-punitive; emphasis on whole person; diagnosis
- Disadv.: diagnosis; implies treatment of mental disorder is sufficient

---

---

---

---

---

---

---

---

## Basic Models

- **Social**

- Environmental influences
- Improved social functioning and conditions; change environment (local – global)
- Benefits: emphasise social support, skills; integrates well with existing models
- Disadv.: projection of blame; implies social intervention is sufficient

---

---

---

---

---

---

---

---

## Basic Models

- **Biological** (WHO, 2004)
  - genetic inheritance; brain chemistry
  - Pharmacological intervention
  - Benefits: empirical support; immediate intervention
  - Disadv.: does not recognise underlying, complex disorders; simplistic; limited long-term support

---

---

---

---

---

---

---

---

## Integrated Models

- a post-modern age...
- **Theories of integration** (Norcross & Goldfried 1992)
  - different forms of integration
    - “technical Eclecticism”  
what’s best for the individual.
    - “theoretical Integration”  
converging theory
    - “common factors”  
a clinical strategy; mid-level integration

---

---

---

---

---

---

---

---

## Integrated Models

- **Biobehavioural**
  - Develops biological and behavioural
  - Identifies ‘physical’ adaptations in the brain to environmental change / stimulus
- **Social-learning** (Bandura)
  - Develops social and behavioural/cognitive models
- **Biopsychosocial**
  - Seeking to integrate across all levels / models
  - Potentially eclectic (current care pathways)
  - Area of contemporary theory and research

---

---

---

---

---

---

---

---

## Integrated Models: The Cycle of Change

- **Basic outline** (see Prochaska & DiClemente, 1983; DiClemente, 2003)
  - Developed through smoking cessation research
  - Theory of 'Change' - how behaviour 'changes'
  - 'common factors' integration – Motivation is central
  - Incorporates range of other models' interventions
  - Change is sequential and irregular

---

---

---

---

---

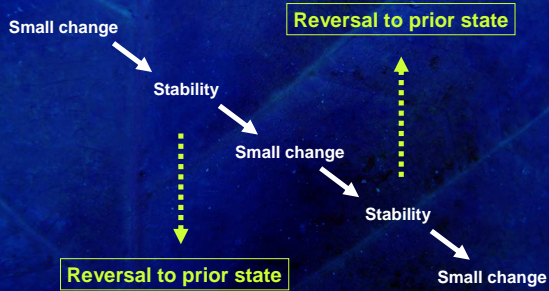
---

---

---

## Integrated Models: The Cycle of Change

### CHANGE



---

---

---

---

---

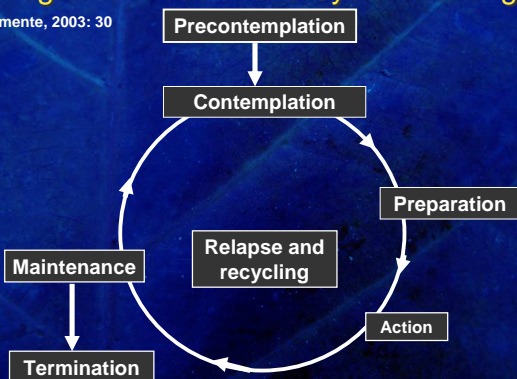
---

---

---

## Integrated Models: The Cycle of Change

DiClemente, 2003: 30



---

---

---

---

---

---

---

---

## Integrated Models: The Cycle of Change

Stages of change and treatment tasks		
Precontemplation	Increase concern and hope for change	Advice Harm Min.
Contemplation	Tip the decisional balance	Motivational Int. Brief Interventions
Preparation	Commitment and effective plan	Harm Min. Pharmaceutical Int. Motivational Int.
Action	Problem solving, support self efficacy	Behavioural Int. Support Networks
Maintenance	Prevent relapse: resolve context problems	Therapy/counselling CBT Support networks

---

---

---

---

---

---

---

---

---

---

## Integrated Models: The Cycle of Change

### Exercise:

- 10 mins
- Groups of four:
  - Do you use the Cycle of Change?
  - How?
  - Strengths and weaknesses

---

---

---

---

---

---

---

---

---

---

## Integrated Models: The Cycle of Change

- **Strengths**
  - Popular and accessible
  - Comprehensive intervention framework
  - Motivation is central
  - Reflects experience
  - Adaptable to multi-drug use
  - Recognises & accepts relapse
  - Non-judgemental

---

---

---

---

---

---

---

---

---

---

## Integrated Models: The Cycle of Change

- **Criticisms** (West, 2006)
  - Offers no aetiology
  - ‘stages’ are arbitrary / questionable meaning
  - ‘stages’ lack empirical rigour / operationalisation
  - Assumes coherent, stable planning
  - Neglects behavioural models / influence on behaviour
  - Dodgy empirical evidence
  - “...it is just a statement of the obvious” (*ibid*: 69)
  - Labelling can lead to inappropriate interventions  
e.g. being a ‘precontemplator’ should not preclude psychotherapeutic options’

---

---

---

---

---

---

---

---

- Beck, A. T., F. D. Wright, C. F. Newman, and B. S. Liese. 1993. *Cognitive Therapy of Substance Abuse*. New York.: The Guilford Press.
- DiClemente, C. C. 2003. *Addiction and Change: How addictions develop and addicted people recover*. New York: The Guildford Press
- Jary, D., and J. Jary. 2000. *Collins Dictionary of Sociology*. 3rd ed. Glasgow: HarperCollins Publishers.
- Khantzian, E. J. 1997. The Self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard Review of Psychiatry* 4 (5):231 - 244.
- Marlatt, A, and J Gordon. 1985. *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviour*. London: Guilford Press.
- Norcross, J. C., and M. R. Goldfried, eds. 1992. *Handbook of Psychotherapy Integration*. New York: BasicBooks.

---

---

---

---

---

---

---

---

- Prochaska, J. O. and DiClemente, C. C. 1983. Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390 – 395.
- Skog, OJ. 2000. Editorial: Addict's Choice. *Addiction* 95 (9):1309 - 1314.
- Vuchinich, R. V., and N. Heather. 2003. *Choice, Behavioural Economics and Addiction*. Cambridge: Pergamon.
- West, R. 2001. Editorial: Theories of Addiction. *Addiction* 96:3 - 13.
- West, R. 2006. *Theory of Addiction*. London: Blackwell Publishing.
- World Health Organisation. 2004. *Neuroscience of psychoactive substance use and dependence*. Geneva: WHO.

---

---

---

---

---

---

---

---