

# **Self-Medication Theory and Addiction as a Self-Regulation Disorder**

**(For SoAP Teleconference – November 8, 2019)**

**Definition of the SMH** ( Mention SMH vs SMT change – I will use both)

**Addictive drugs have their appeal and become compelling principally for two reasons:**

- (1) They relieve human psychological suffering and,
- (2) There is a considerable degree of specificity in a person's drug-of- choice.

**The SMH is a paradigm for understanding and treating addictive disorders; it is a paradigm for getting at the human psychological vulnerabilities at the root of addictive disorders.**

## **Background**

- The scourge of Opioid dependency then (1970) and now (2019)

- TCH – 1970.s Heroin epidemic. Community alarm. The commissioner of Health mandate to develop a program
- EJK in middle of Psychoanalytic training – “Take notes”
- Decision to start a methadone program (emphasis on a psychologic-social component and why it made sense)
- Also a stimulus for the development of ideas and approaches that were unique for that time, and in particular, the idea that addiction was not grounded in pleasure but in pain.

### Some Premises

- Addictive behavior is grounded in the human penchant (especially in the infant, but persisting into adulthood) for seeking comfort and contact, *not pleasure or self-destruction.*
- Addictive drugs, despite their powerful appeal, are not universally appealing. NB-Many use but few get addicted

- The SMH supplies clues and understanding why these drugs are more captivating for some and not for others.
- Examples
  - PTSD
  - BPD
  - Nicotine Dependence
  - ADHD
  - Bipolar Disorder
  - Schizophrenia (nicotine, alcohol, cocaine)
  - THIS CO-OCCURRENCE IS TOO GREAT TO BE BY CHANCE
  - Factors of temperament and personality – i.e. how these factors are involved in processing feelings/affect

### Self-Medication Theory and the Appeal of Addictive Substances

- 1970 commencement of the TCH Methadone Program
- 1985 and 1997 articulation of the SMH
- Trends – the SMH trivialized, demonized, or widely endorsed, *the latter especially by clinicians and clinical investigators*

- Early focus (1970s and 1980s) primary focus on painful affects
- My initial stereotype – anti-social and menacing (counter-transference).

Clinical evaluations began to quickly reveal patients' suffering and preeminent vulnerability

- [Insert - the parallel re specificity issue with changes in 1960's psychopharmacologic nomenclature
- Stirred embryonic thinking of the SMH
- SUDs as a self-regulation disorder
- Emphasize the “discovery.”
- Beyond the TCH – I took all comers in private practice
- Appeal of the main classes of addictive drugs (from the 1997 update of the SMH) (SM as a telltale -not just diagnosis-- and guide for treatment :

- *Opiates. Besides their general calming and “normalizing” effect, opiates attenuate intense, rageful, and violent affect. They counter the internally fragmenting and disorganizing effects of rage and the externally threatening and disruptive effects of such affects on interpersonal relations.*
- *Central nervous system depressants (including alcohol). Alcohol’s appeal may reside in its properties as a “superego solvent. However, in my own experience, and based on observations by Krystal, short-acting depressants with rapid onset of action (e.g., alcohol, barbiturates, benzodiazepines) have their appeal because they are good “ego solvents.” That is, they act on those parts of the self that are cut off from self and others by rigid defenses that produce feelings of isolation and emptiness and related tense/anxious states and mask fears of closeness and dependency. Although they are not good*

*antidepressants, alcohol and related drugs create the illusion of relief because they temporarily soften rigid defenses and ameliorate states of isolation and emptiness that predispose to depression.*

- *Stimulants. Stimulants act as augmentors for hypomanic, high-energy individuals as well as persons with atypical bipolar disorder. They also appeal to people who are de-energized and bored, and to those who suffer from depression.*

*In addition, stimulants, including cocaine, can act paradoxically to calm and counteract hyperactivity, emotional lability, and inattention in persons with attention-deficit/ hyperactivity disorder.*

*(Khantzian, 1997).*

## ADDICTION AS A SELF-REGULATION DISORDER

- Criticisms and inconsistencies in the SMH led me to begin to think about what else beyond painful affects are dysregulated in addictive disorder and to consider addiction as a self-regulation disorder
- But first I would like to emphasize the primary importance of affect life, based on my experience, in addictive disorders
  - Affects cut across all aspects of self-regulation in the development of addiction
  - Affects are the organizing basis for self-experience  
(Stolorow et al 1995)
  - Affects are the foundation for a sense of well-being  
(Kohut 1970)
  - Affects are the currency for human connection and attachment (Bowlby 1973)
  - Affects are the primary ingredient for guiding behavior, especially self-care (Khantzian and Mack 1983)

- What is disordered in SUDs
  - Disordered emotions (extremes – alexithymia or intense)
  - Disordered sense of self/self-esteem (fragmented, lost)
  - Disordered relationships (substitute inanimate attachment)
  - Disordered self-care (developmental deficits)
- Comment on drug effects on disordered emotions, self-other relations, and self-care (some examples):
  - **Affects**
    - stimulants enlivening or activating;
    - if defensively cut off low to moderate doses of alcohol allow feelings of closeness or warmth not ordinarily;
    - if *intense or overwhelming*, opiates are powerful containing agents
  - **Self-other relationships**
    - Opiates calm feelings of poor self-cohesion and fragmentation;
    - alcohol connects the unconnected;

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- Narcissistic defenses of disdain and self-sufficiency, which produce interpersonal isolation, are temporarily lifted by stimulants or low to moderate doses of alcohol and allow connection to others that otherwise are unallowable

- **Self-Care**

- Absence of alarm, fear, or worry;
- Absence of anticipatory shame or guilt;
- this deficit interacts malignantly with the pain and suffering involved with regulating emotions, self-esteem, and relationships to make addictive behavior and attachment more likely.
- Comment – Anticipatory shame and guilt vs. after-the-fact shame and guilt

### **Conclusion – The SMH, a Humanistic Paradigm**

I remain convinced that the SMH continues to have important clinical implications and heuristic value in furthering the treatment of addictive disorders and targeting and relieving the suffering associated with co-occurring disorders.

Nowhere is this more apparent than in conditions as PTSD. The SMH is rooted in a humanistic and empathic tradition that helps patients and society to understand and accept, rather than to condemn and reject, individuals with these disorders. Also, in many respects it remains an insufficiently investigated paradigm that can be further explored and tested empirically.