Is addiction a mental illness?

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Bibliography:


Taking away the stigma against addiction by calling it a disease is harmful because doing so prevents addicts from gaining any incentive to quit. The effects of environments and choice have been proven by studies in which animals in worse environments chose to consume more of a given drug. Many addicts, such as Vietnam veterans addicted to heroin, as well as 60 percent of smokers in America, have quit without intervention. In addition, it is clear that “addicts” have an incentive to treat addiction as a disease in order to sue tobacco companies and collect large sums of money from insurance companies for treatment.


Addiction does not have much in common with diseases, and thinking of it as a disease prevents us from accepting new approaches and treatments. Addiction has no infectious agent, biologically degenerative condition, or pathological biological process. It is a compulsive symptom rather than a disease because an addictive acts are caused by emotionally significant events, and these acts can be controlled if time is taken to understand why the emotional events are so significant. In addition, approaching addiction as a compulsive symptom opens the door to treatment methods.


If a person sees the tendency of an addiction to grow unstoppably and feels the helplessness that often accompanies an addiction, he or she will accept the idea that addiction is a disease. However, the negative side of that is a release from responsibility. Accepting this idea means that an addict can do nothing about their predicament (at least not without intervention from others). The idea gives addicts an excuse to continue using addictive substances.


The idea that addiction is a disease and that it is caused by a “hijacked” brain is false because a hijacking is performed by force, where as addictive substances are consumed by choice. Also, this idea is counterproductive because it prevents addicts from taking responsibility
for their actions. At the same time, there is a degree of constraint of choice because people only choose to consume addictive substances; no one chooses to get addicted. Therefore, the best path is to admit that addiction includes ingredients from both sides rather than limiting ourselves with inaccurate black-and-white thinking.


Addicts monitor consumption according to given circumstances, which means that their addiction is not beyond their control, and addiction is not a disease. The common belief is that abstract psychological entities such as emotions are caused by physical processes (this notion is an integral part of the disease model of addiction). However, the reverse can be true. Many believe that dopamine is involved in the reward/reinforcement process that keeps addicts addicted. On the contrary, animal studies have shown that dopamine is released in response to novelty and expectation of a reward, rather than an actual reward. Plus, Alcoholics Anonymous (a popular treatment method in accordance with the disease model) is religious in nature according to the Supreme Court’s standards, and using religion as a clinical technique is unacceptable. In addition, the disease model counterproductively releases the addict from responsibility.


Substance abuse disorders often occur in patients with other psychiatric illnesses, yet few such individuals receive treatment for their conditions despite the serious health and other consequences that often result. This article talks about the common vulnerabilities of addiction and mental illnesses, it also mentions integrated treatments for dealing with people diagnosed with mental illnesses and substance abuse. Substance abuse and mental illness are comorbid and when treating patients one has to be aware of that fact.

Sharon Kirkey. (2008) Recognize Internet addiction as a mental illness,

MD urges; Users experience cravings, withdrawal, psychiatrist says. *Ottawa Citizen, NEWS; Pg. A1, The Ottawa Citizen*

Internet addiction including "excessive gaming, sexual pre-occupations and e-mail/text messaging" is a common compulsive-impulsive disorder that should be added to psychiatry's official guidebook of mental disorders. Like other addicts, users experience cravings, urges, withdrawal and tolerance, requiring more and better equipment and software, or more and more hours online, according to Dr. Jerald Block, a psychiatrist at the Oregon Health and Science University in Portland. Dr. Block says people can lose all track of time or neglect "basic drives," like eating or sleeping. Relapse rates are high, he writes, and some people may need psychoactive medications or hospitalization. He argues that the phenomenon warrants being
included in the Diagnostic and Statistical Manual of Mental Disorders, but the research into Internet addiction is in its infancy.

Recovery From Addiction and From Mental Illness: Shared and Contrasting Lessons.


In this chapter they compared and contrasted the experiences and processes of recovery from addiction with recovery from psychiatric disability. Second, they explored lessons learned within the addictions field about recovery groups and their potential role in long-term recovery. Third, they explored what has been learned within recovery advocacy movements in the addictions field that may have relevance to parallel movements within the mental health field. Their focus was on lessons learned within the addictions field that may have relevance to personal recovery from psychiatric disability and to mutual-aid and political advocacy movements organized by and on behalf of people who have experienced psychiatric disability.


Individuals with schizophrenia use psychoactive substances more frequently than the general population. The genetic vulnerability to develop schizophrenia may also increase risk for the development of substance use disorders. They assessed the rates of substance use disorders and nicotine use in non-psychotic siblings of individuals with schizophrenia. They found that the non-psychotic siblings of individuals with schizophrenia have increased rates of alcohol and cannabis use disorders, as well as nicotine use, when compared to the siblings of community controls. These findings support prior research indicating that non-psychotic siblings had higher rates of smoking and cannabis use disorders than controls.


Individual differences in traits such as impulsivity involve high reward sensitivity and are associated with risk for substance use disorders. The ventral striatum has been widely implicated in reward processing, and individual differences in its function are linked to these disorders.
Dopamine plays a critical role in reward processing and is a potent neuromodulator of VS reactivity. Moreover, altered DA signaling has been associated with normal and pathological reward-related behaviors. They further suggest that altered VS reactivity may represent a key neurobiological pathway through which these polymorphisms contribute to variability in behavioral impulsivity and related risk for substance use disorders.


Review information relevant to the question of whether substance-induced mental disorders exist and their implications. The results of any specific study depended on the definitions of comorbidity, the methods of operationalizing diagnostic criteria, the interview and protocol invoked several additional methodological issues. The results generally support the conclusion that substance use mental disorders exist, especially regarding stimulant or cannabinoid-induced psychoses, substance-induced mood disorders, as well as substance-induced anxiety conditions. The material reviewed indicates that induced disorders are prevalent enough to contribute significantly to rates of comorbidity between substance use disorders and psychiatric conditions, and that their recognition has important treatment implications. The current literature review underscores the heterogeneous nature of comorbidity.