

Commentary on: Are we overpathologizing everyday life? A tenable blueprint for behavioral addiction research

Addictions as a psychosocial and cultural construction

MARTIAL VAN DER LINDEN*

Cognitive Psychopathology and Neuropsychology Unit, Psychology Department, University of Geneva

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This commentary proposes a complementary perspective to that developed by Billieux, Schimmenti, Khazaal, Maurage and Heeren (2015). The addiction-as-disease approach tends to sideline explanatory factors of a psychosocial, cultural, political, or historical nature. I therefore suggest taking into account not only the personal characteristics (loss of self-control, impulsivity) related to the disease model, but also the social determinants of addictive behaviors (weak social ties, social exclusion, hyperindividualism, poverty, unemployment, etc.). Moreover, the disease model of addiction removes addictive behaviors from the cultural and historical contexts that shape them. I argue that the cultural and historical reasons for which certain factors (such as loss of self-control) became so important in the explanation of addictive behaviors should be more thoroughly considered.

Keywords: behavioral addictions, addictive behaviors, addiction-as-disease approach, psychosocial and cultural approaches, individualized psychosocial formulation

In the last few years, the domain of addiction has expanded spectacularly. It has included, beyond substance addictions, an increasing number of behavioral addictions involving a great variety of behaviors and activities, such as sex, work, shopping, attachment to others (co-dependency), physical exercise, gambling, Internet use (social networking, gaming, pornography), and eating. Recently, more specific types of addictions have been described, namely, tanning addiction (Kouros, Harrington & Adinoff, 2010), fortune telling addiction (Grall-Bonnec, Bulteau, Victorri-Gigneau, Bouju & Sauvaget, 2015), educational studying addiction (Atroszko, Andreassen, Griffiths & Pallesen, 2015), dance addiction (Maraz, Urbán, Griffiths & Demetrovics, 2015), and even a subtype of dance addiction, Argentine tango addiction (Tharghetta, Nalpas & Perney, 2013). Thus, the potential number of behavioral addictions seems infinite. By presenting, in part seriously, in part ironically, a model railroading addiction (based on the DSM-IV-TR criteria for pathological gambling, the words *model railroading* being substituted for the word *gambling*), Mihordin (2012) showed how easy it is to create a new form of addiction. In addition, the more we attribute a psychiatric diagnosis of addiction to persons presenting certain problematic behaviors, the more we increase their numbers (Peele, 2004). Thus, following the identification of the Argentine tango addiction, we may see multiple forms of dancing addictions appear, involving rock and roll, twist, rumba, waltz, java, Charleston, etc. – an inexhaustible source of publications! According to Reinerman and Granfield (2015), it looks like we have become addicted to addiction. Indeed, the notion of addiction is more and more frequently used by a wide range of professionals, and even by ordinary citizens, to serve as an all-purpose explanation for a great variety of everyday difficulties or problems.

Billieux, Schimmenti, Khazaal, Maurage and Heeren (2015) provide a compelling view regarding the overpathol-

ogization of everyday life behaviors induced by the “addiction model.” They also convincingly identify the methodological and theoretical limits of this approach and show how it leads to the neglect of the heterogeneity of the so-called addictive behaviors, as well as of their multifaceted and context-dependent nature. I fully concur, but I suggest a complementary perspective: addictions viewed as a psychosocial and cultural construction.

Substance and behavioral addictions are dominantly considered as a chronic, relapsing (brain) disease and are mainly explained in terms of biological (genetic, physiological, or neurological) factors. This addiction-as-disease approach tends to sideline explanatory factors of a psychosocial, cultural, political, or historical nature (Reinerman & Granfield, 2015; Suissa, 2006). Interestingly, Sussman, Lisha and Griffiths (2011) examined the prevalence of 11 potential addictions (tobacco, alcohol, illicit drugs, eating, gambling, Internet, love, sex, exercise, work, and shopping) among U.S. adults (based on data from 83 studies). The results suggest that, most plausibly, about 47% of the U.S. population had an addictive behavior, with serious negative consequences, in a 12-month period. The authors concluded that it may be useful to think of addictions not only in terms of personal factors, but also as problems of lifestyle, modeled by social-environmental factors.

From this point of view, Suissa (2014), inspired by the work of Peele (2004), proposes adopting a psychosocial perspective of addiction by including social determinants (weak social ties, social exclusion, hyperindividualism,

* Corresponding address: Martial van der Linden; Cognitive Psychopathology and Neuropsychology Unit, Psychology Department; Bd du Pont d'Arve, 40, 1205, Geneva, Switzerland; Phone: +41 (0) 22 379 93 45; E-mail: martial.vanderlinden@unige.ch

poverty, unemployment, etc.) and not just personal characteristics (loss of self-control, impulsivity) related to the disease model. More specifically, he considers that we are all candidates for developing different addictive behaviors. However, the potential to become dependent is higher when the motivation of the person is to escape from difficulties such as work stress, feelings of loneliness, feelings of emptiness, boredom, low self-esteem, identity problems, etc. This motivation may initiate a “cycle of vulnerability to addiction,” in which the addictive behavior is intended to “anesthetize” the negative emotions; this behavior temporarily alleviates distress, but the person is again confronted with reality (malaise, guilt, low self-esteem), which contributes to the continuation and strengthening of the cycle (see also Billieux, Philippot et al., 2015, for a similar interpretation concerning mobile phone overuse).

At a more global level, Reinerman and Granfield (2015) indicate that biological models of addiction remove addictive behaviors from the cultural and historical contexts that shape them. As an example, loss of self-control is considered an important factor in the brain disease theories of addiction. The social and cultural reasons for which self-control became so important and yet so difficult to maintain should thus be taken into account in the explanation of addictive behaviors. Reinerman and Granfield (2015) mention, among such reasons, the proliferation of pleasures in modern society and the idea that ordinary citizens have a right to pleasure; the encouragement of immediate gratification by mass consumption cultures (while persuading consumers that shopping is a core leisure activity); and the existence of various types of social and cultural dislocations from families, communities, traditions, and ways of life that guide and constrain individuals. Paradoxically, modern society encourages individuals to exercise self-control and restraint (to “take responsibility” for their actions), but, at the same time, encourages them to consume and to abandon themselves to the pleasures of self-fulfillment. Society is thus organized in part to undermine self-control. Under these conditions, more and more people will show increasing difficulties in regulating their desires.

Similarly, Reith (2007, 2013) argues that the emergence of “pathological gambling” as a distinct social phenomenon must be understood from the contradictions of late-modern consumer societies. Moreover, in a series of longitudinal and qualitative studies (Kristiansen, Trajberg & Reith, 2015; Reith & Dobbie, 2011, 2012, 2013), she and her colleagues reveal the importance of social networks (family, friends, colleagues), as well as geographical-cultural environment, social class, age, and gender, in the initiation of gambling. Their findings indicate that young people start gambling not because of purely personal characteristics, but through a social process within significant social networks involving a transfer of skills and knowledge (in particular, the attribution of specific meanings to gambling). Reith and colleagues also show that gambling behavior is highly variable over time (with four different trajectories of behavior: progression, reduction, consistency, and nonlinearity) and that this variability is related to material factors such as employment, environment, and social support. Finally, they observe that the recovery processes are embedded in wider social relations and revolve around shifting concepts of self-identity.

In conclusion, we need an important revision of the way we think about addictive behaviors from a clinical point of view. In a paper entitled “Imagine there is no diagnosis, it’s easy if you try,” Kinderman (2015) suggests that, rather than using diagnostic labels for putative disorders, we should instead make a list of a person’s problems. In order to understand these well-defined and specific problems, we should develop an individualized psychosocial formulation in which we incorporate social factors, circumstantial factors, and biological factors, as well as the psychological processes that mediate the responses to those factors. In terms of research, addiction studies should necessarily be multidisciplinary and holistic (Reinerman & Granfield, 2015).

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