



ADDICTION TREATMENT SHOULD BE THE WORK OF LIBERATION:

But What Does Such a Model Look Like?

Abstract

This article outlines a liberation-focused model of addiction treatment. Drawing on the Latin root word "addictus", addiction is seen as slavery and freedom, rather than the cessation of drug and alcohol use, is proposed as a viable, alternative treatment goal. Freedom is defined as: (1) the capacity to create a life of social and internal complexity and multiplicity; (2) the ability to make choices from an array of options; and (3) the possibility of engaging in long-term, goal-directed behavior. This vision of personal liberation is then embedded within a biopsychosocial model of care and treatment. Examples of how biomedical, psychological, and social interventions can each serve to promote the goal and experience of freedom and liberation are provided. Engaging in identity projects and using harm reduction interventions and philosophies are also seen as key to this transformative journey.

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All forms of psychopathology impair the freedom of the individual, but addiction is a particularly intense form of slavery, [argued](#) psychoanalyst and addiction psychologist Dr. Jerome Levin.

This in itself is not a particularly new insight; in fact, the word addiction [is rooted](#) in a word for slavery¹. Dr. Levin's gift, however, is in his vision of treatment as journey from slavery to freedom. If that is true, then treatment—in all its forms—is the work of *liberation*.

What then, are the essential paradigms, principles, and interventions that would serve a liberation-centered approach to addiction treatment?

Anchoring my thoughts in the [Scientific/Humanist Model](#), I would first turn to the work of [Dr. Andrew Tatarsky](#), who argues that “Complex problems require complex solutions.” He reflects a belief shared by a number of contemporary addiction psychotherapists that addictions are multifactorial in both etiology and experience. Given this, I believe a biopsychosocial approach to addiction treatment to be the best framework.

To say that addiction is a biopsychosocial disorder and, that we need treatments appropriate to that model, is a commonplace. In reality, however, *biopsychosocial is hard!* It is challenging to

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simultaneously see someone who is using substances in a problematic, endangering, or addictive manner through the respective lenses of their biology, their psychology, *and* their social reality.

It is a paradigm that few, in fact, seem to be able to embrace philosophically and actualize clinically; it seems much more common for clinicians to use one or two of the three. Nonetheless, I believe that utilizing a biopsychosocial model *is* the best way to forge a path to freedom.

What is freedom? In the clinical context of problematic substance use and addiction, I see freedom has having three core components:

1. The ability to live a life of both internal and social complexity and multiplicity.
2. The possibility and power to choose from an array of options.
3. The ability to consistently engage in purposeful and meaningful goal-directed behavior over an extended period of time.

Using a liberation-focused approach to treatment, the central problem is addiction and the fundamental goal is freedom. In my work, the ultimate, but not necessarily immediate, aim of treatment is that patients attain a state of either abstinence or what I call non-addictive use.

During the journey, harm reduction and substance use management techniques are an essential component of care, as many will want to address a number of issues along the way before they radically diminish or cease their substance use.

Looking at the biological/medical, psychological, and social approaches to treating addiction, we should assess each according to whether or not the intervention increases freedom and the ability to live a complex and self-directed life.

As I think will be clear, each of these visions has something to offer—but none, alone, is likely to be complete.

Biological/Medical Approaches

For nearly two decades, the National Institute on Drug Abuse has been championing the idea that addiction is a [*brain disease*](#).

This model clearly has its supporters. Jerry Stahl, the writer, [put it](#) this way: “Being a junkie is not a lifestyle choice—it’s an imperative of molecular chemistry.”

It also has its [critics](#). I think that we have probably reached the point where it is clear that the term “brain disease” is a misnomer, and that it would be more accurate to understand addiction through the lens of a “Brain Dysregulation Model.”

In any case, I personally find the [NIDA PET scans](#) to be meaningful—especially those illuminating the process of neurotransmitter downregulation. As a clinician, however, the most compelling evidence for a brain-based vision of addiction can be seen in the fact that medications that target the brain lead to experiences of greater freedom and healthier outcomes.

Our medical, neuroscientific, pharmacological, and neurobiological understandings of addiction are all rooted in the discovery and creation of Methadone Maintenance by Dr. Vincent Dole, Dr. Marie Nyswander, and Dr. Mary Jeanne Kreek at the Rockefeller Institute in the 1960sⁱⁱ. In a

striking parallel to our contemporary situation, there was a heroin epidemic in New York City in the 1950s and early '60s. Heroin overdose was a leading cause of death among young people. Under Dr. Dole's leadership, the team was seeking an opioid that could serve as a maintenance medication. They began with morphine and went on to try heroin, hydromorphone, codeine, oxycodone, and meperidine. None of these medications resulted in stabilization. However, when they tried methadone, something extraordinary occurred. Dr. Dole [described it](#) this way:

“A remarkably different result was seen when, in the course of the scheduled testing, methadone was administered. The fluctuation in clinical state became less and then disappeared. Doses became stable. The patients seemed normal. Most remarkably, their interests shifted from the usual obsessive preoccupation with timing and dose of narcotic to more ordinary topics.”

Dr. Nyswander, [remembering](#) the discovery, spoke about the surprising changes that occurred:

“The older addict began to paint industriously and his paintings were good. The younger started begging us to let him get his high school-equivalency diploma. We sent them both off to school, outside the hospital grounds, and they continued to live at the hospital (p. 114).”

The birth of Methadone Maintenance was a striking example of the use of a pharmaceutical intervention leading to increases in personal complexity. Earlier in the study, the patients were completely focused on issues of dosing and withdrawal; once they received an adequate dose of methadone, they obtained the internal freedom to consider, explore, and take action on other concerns.

Dr. Dole, I believe, deeply appreciated that this was a profound, yet partial, victory. As he put it:

“The treatment, therefore, is corrective but not curative for severely addicted persons.” He and his colleagues likened opioid addiction to diabetes. One could renew one’s freedom by taking the medication each morning; unfortunately, [one would likely lose one’s freedom by discontinuing to do so](#).

The freedom-enhancing properties of methadone can be found in other medications as well. Tom, in the HBO Addiction movie, [Topiramate: A Clinical Trial for Alcoholism](#) reported on his experience of taking topiramate for 10 weeks. First he speaks of the importance of making a decision, of taking a stand against the drinking, and then he says:

“But I think that medication made it so much easier for me. Today I can pick and choose what I want to do. I can determine what is going to happen tomorrow and I’m not going to drink.”

Again, in those wonderful words—“I can pick and choose what I want to do”—we can see a dramatic increase in autonomy and the capacity for self-direction.

In a more controversial example, [Amanda](#), who had a successful Ibogaine treatment, described her experience this way:

“I’ve been clean ever since, a year and a half now. I’ve got a job that I love, an amazing new boyfriend, my relationships with my family are healed; my life is totally different than it was. I’m healthier and happier than I can ever remember being. I have no craving or desire for the drugs that used to control my life. I’ve been given a chance to hit the reset button, to begin my life again. Ibogaine is not a miracle drug. You have to really want it, and you have to be willing to do the work, and it is some of the most challenging work I’ve ever done in my life.”

Again, we see the gift of freedom returned. Her life is far more self-directed and much more complex than it was when using.

Psychological/Psychotherapeutic Approaches

Contemporary psychological and psychotherapeutic approaches to addiction treatment are centered on four areas of endeavor.

The first is that the therapeutic alliance or therapeutic relationship is the foundation of all catalytic work. [Numerous studies](#) have shown how crucial this is in the healing process. I have come to see this as consisting of six components: (1) empathic listening; (2) being authentic while not being overly self-revealing; (3) maintaining a sense of optimism and a belief that the patient always has the capacity to change and get better; (4) having personal courage and a willingness to skillfully engage with the darkness and with areas of pain and difficulty; (5) acting with determination and persevering until the work is done; and, most importantly, (6) love. Dr. Erich Fromm, in [The Art of Loving](#), defined it this way:

“Love is the active concern for the life and growth of that which I love.”

I believe that the core values of connection, care, action, and growth and development that are manifest in this definition are a touchstone to guide our work. The power of love is not to be underestimated. When Evelyn Milan [told the story](#) of her recovery from drug addiction, she put the experience of being loved and accepted at the Lower East Side Harm Reduction Center at the heart of her transformational process:

“I finally started feeling like a human being again, and that is because I was being loved and treated like a person should be treated. I was special in other people’s eyes. I count as someone

special and not just as something unacceptable in society. That has made a difference in my life and my recovery.”

The second area of endeavor is ambivalence. Ambivalence, at its most essential, is the understanding that in all cases of problematic or addictive substance use, there is a part of the person that wishes to continue to engage with the substance and a part that wants something different. As Dr. Debra Rothschild has argued, for many patients, these two sides are somewhat dissociated. That is, the part that wants to use is typically dominant at night and the part that wants something different is, perhaps regretfully, present the next day.

An essential part of the therapeutic work is to not only invite the patient to give voice to both sides, but also to continually promote a creative encounter between these two polarities. Methods of working with this include [Contingency Management](#), [Motivational Interviewing](#), [the Decisional Balance](#), and [Chairwork Dialogues](#).

The third area was crystallized by Dr. Edward Khantzian, who argued that that problematic and addictive drug use, on the one hand, and psychopathology and inner pain, on the other, are deeply connected and intertwined. At the core of his [Self-Medication Hypothesis](#) was the belief that “Suffering is at the heart of addictive disorders” (p. 217). The reality of this experience was captured by a heroin-addicted man named [I.Thaca](#), who wrote:

“After a lifetime of depression, and long bouts of self-medicating with alcohol, cocaine, and whatever else was available, heroin was a godsend. In fact, I can truly say that junk was one of the best things that’s ever happened to me.”

Similarly, Ruth Fowler [remembered](#):

“Girl in pain drinks and takes something – anything – to stop the feeling. Girl wakes up in more pain, is more angry. Girl does more to block it all out.”

Here we see the centrality of pain and darkness in experiences of problematic substance use. To be clear, however, the path to addiction may well be through anguish related to physical pain. In fact, [chronic pain](#) is the number one medical problem in America and our current prescription opioid addiction epidemic is related, at least in part, to this.

Dr. Alan Marlatt, in turn, created [Relapse Prevention](#), which has served as the basis for all the empowerment therapies. The model, which has the specific goal of changing drug use patterns, has several core components. These include: (1) understanding that cravings, urges, lapses, and relapses do not occur at random—they occur in response to specific and personal internal and external high-risk situations and experiences; (2) these high-risk situations and internal states can be identified; (3) addictive and problematic substance use are fundamentally maladaptive ways of coping with stressful situations; and (4) healing and recovery involve empowering patients and helping them learn and master new and more effective ways of coping with difficulties and stress. The specific interventions will include micro-analyzing drug-use patterns; mapping out high- and low-risk situations and internal states; engaging in cognitive restructuring; learning drug refusal skills; developing an assertive voice; and practicing urge-surfing.

The depth work will, ideally embrace the essential tools of psychotherapy: building a relational connection; reinterpreting experience in more adaptive ways through cognitive restructuring; exposing oneself to feared and frightening situations and experiences; developing positive reinforcement systems to help increase motivation and the development of skills; developing one’s voice through assertiveness training; enacting or re-enacting traumatic or difficult situations from one’s past, present, or future; resolving inner conflict through giving voice to

one's internal voices, modes, or selves; mitigating the impact of the Inner Critic; nurturing the growth and empowerment of the Ego or Inner Leader; claiming the future through values clarification and the pursuit of [Existential Heroism](#); dealing with stress and illness through the practice of relaxation therapy; and developing one's capacities for emotional regulation through the development of a meditative practice.

It is the ability to work on both of these dimensions, on the *Horizontal* and the *Vertical* as Dr. Leon Wurmser [called them](#), that is at the center of the struggle for freedom. Sometimes the clinician will focus on the drug use, sometimes the underlying pain, and sometimes both simultaneously. It is this way of working that is the hallmark of those psychological and psychotherapeutic approaches to addictions that are truly capable of embracing and effectively addressing complexity.

Social Approaches

The social dimension of substance use—especially drinking—has been central part of the experience for thousands of years. Drinking and drug use can serve to build connections, to acquire membership in a group or social network, and to affirm membership in a particular group or subculture. Elissa Schapelle [remembered](#):

“Our days of wild drinking were very much tied into a time and place – primarily downtown New York in our twenties and into our thirties – when we were finding ourselves, our circle of friends, our voices as creative people.”

Coming out of the Harm Reduction movement of the 1980's, there has been an increasing emphasis on the connection between problematic or addictive substance use and social oppression. In the Harm Reduction Coalition's [Principles of Harm Reduction](#), one passage reads:

“[HRC] recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.”

Carol Draizen [captured](#) the reality of socially-induced substance use this way:

“Their use of consciousness-altering chemicals is not only a coping mechanism but a rational reaction to an irrational situation; Moreover, the vast majority of the addicted poor living on the streets have life histories of severe, cumulative trauma, made worse by the inhuman conditions homeless people face. Getting high is also one way to have a little privacy – at least in your own mind.”

The grassroots, public-health centered Harm Reduction movement has, for the most part, focused on two primary goals. [These are](#): (1) helping drug users to stay alive and not die from the immediate use of their drug user; and (2) working with them to maintain their health over the short- and long-term.

This is reflected in such practices as syringe and needle exchange, low threshold methadone provision, naloxone distribution for overdose prevention, safe injection sites, safer using techniques, heroin maintenance, drug checking, and [substance use management](#) approaches.

Harm reduction has been one of the most astounding success stories of the past 30 years—saving the lives and health of untold millions of drug users, their families, and their loved ones.

There is a stream within the movement that: (1) engages in struggle against the devastating impact of prohibition, the drug war, and mass incarceration; (2) supports the right of the individual to use the substances that he or she wishes to use as long as they do not harm others;

(3) sees itself within a broader movement for human rights; and (4) identifies with and supports other movements for social justice.

While this public health wing of the harm reduction movement has clearly identified itself as a force for human liberation, it has not yet made the issue of liberation from addiction a central concern.

Dr. Bruce Alexander has articulated a somewhat sophisticated vision of the link between social disruption and addiction. He argues that all human beings seek out connection to other humans—as well as to groups and institutions. This is a deep and profound drive and our psychological, social, and cultural health are dependent on the degree to which we are able to successfully accomplish this goal. This form of connection is called *Psychosocial Integration*.

However, negative forces in society, damaging institutions, and problematic family situations can each disrupt this process. This disconnected state Alexander called *Dislocation*. Dislocation is so painful that people will work hard to find ways to achieve psychosocial integration. If they are unable to do this through mainstream cultural or subcultural pathways, they will turn to “substitute lifestyles.” For many, this will take the form of addiction to drugs; addiction, then, is a coping mechanism for different forms of socially- and interpersonally-induced pain. The late Imani Woods [captured this](#) when she wrote:

“Drug use solved a lot of people’s problems in society, particularly around poverty. It helped people feel better about the fact that their family was deteriorating. It helped people feel grandiose instead of in despair. It helped people have social networks and recognition and so forth, and be respected in their society.”

The clinical and therapeutic approach that comes out of this work draws on [Identity Theory](#) and it is specifically focused on rebalancing and, in some cases, expanding the individual's identities and identity hierarchy. [According to](#) Dr. Charles Christiansen: (1) identities are forms of self-definition ("I am a father."); (2) they are relational in as much as their creation, maintenance, are transformation occur in social settings; and (3) they are agentic in that action is need to both create an identity and to maintain it.

There are two other aspects of identity that are central. The first is that people organize their identities into a [hierarchy of importance](#). That is, over time, some identities will have a greater influence on behavior and one's life orientation than others. This usually becomes apparent to people when they are experiencing an identity or role conflict ("My child is sick." "There is an extremely important meeting at work today.")

The second is that people have a greater or lesser number of identities. Dr. Patricia Linville [has argued](#) that having more identities or greater self-complexity contributes to better emotional and physical health. Both of these processes are very relevant to both understanding addictions and helping people overcome them.

As people use alcohol and drugs in a more frequent and problematic way, they begin to develop an addiction identity. This means that the use of the substance is becoming increasingly important—it is taking up more and more time, it interferes with the performance of other identities such as work and family, and it may ultimately lead to the abandonment of those identities altogether.

David Crosby, [the musician](#), summed his experience up this way: "When you take drugs, your whole life centers around taking drugs."

Strikingly, all of these processes mirror the [DSM-5 criteria for Substance Use Disorder](#). Clinically, it is not unusual to encounter patients who have not worked in years, who rarely or unpredictably see their families, and who spend their time centrally focused on the procurement and use of substances.

With some middle- and working-class patients (but not all), the life story often reveals a time in when they enjoyed a range of identities—including those anchored in family, school, work, sports, religion, the arts, politics, and social organizations, among others. Over time, these have been abandoned and/or profoundly damaged as a consequence of the problematic substance use. That is, their personal complexity has been reduced.

In other cases—and this is resonant with Dr. Alexander’s work—a personal history exploration reveals an overall paucity of identities. For reasons of poverty, social oppression, or other life-damaging forces or experiences, individuals have never been able to successfully create, achieve, or maintain viable social identities.

Tragically, the addiction identity is virtually always available.

The answer to this problem is to work with those who are addicted or who are using substances in a problematic manner to retrieve, embrace, or create identities that are (1) meaningful, viable, and reinforcing and (2) can compete with and replace identities based on addiction.

Studies of natural recovery (or recovery without treatment) as well as studies of various forms of treatment have revealed that these identity processes are at work in those who are able to maintain either long-term abstinence or non-addictive drug use. Identity reorganization and transformation is the common factor in all recovery processes.

Dr. Jon Zibbell did a study of the Springfield Needle Exchange, a program run by people actively using drugs. What he found was that many of those who got involved in the program—that is, many of those who embraced an identity as a harm reduction worker—began to stabilize their drug use. As he put it:

“Not only are user-run programs the most viable and effective way to reach active drug users, the users become activists through their work. Since becoming active in our organization, many council members have been able to move away from ‘unmanageable’ drug use towards the stability that maintenance brings.”

Paul McCartney, the Beatle, appears to have had a strong relationship with marijuana. In 2012, [he told](#) *Rolling Stone* that he had decided to stop using cannabis so that he could be a better parent:

“I smoked my share. When you’re bringing up a youngster, your sense of responsibility does kick in, if you’re lucky, at some point. Enough’s enough.”

What McCartney was experiencing was a conflict between his Parent identity and his Addiction identity; in this case, the Parent identity appeared to be winning. Allan Clear, a man who not only benefitted from the 12-step Fellowships, but has been a major leader in the American Harm Reduction movement, [put it](#) this way:

“But I still don’t drink and I don’t do drugs. I do *think* about them but what I have now is much too valuable to give up. To do alcohol and drugs just doesn’t seem worthwhile. It would potentially put everything I have now at risk; well, maybe it wouldn’t really but it has the potential. It’s just not worth it.”

This is what it sounds like when someone has gone through an addiction and gone on to create a freedom-supporting, liberation-affirming identity hierarchy.

Lastly, prohibition, the War on Drugs, and mass incarceration have done terrible things to the people, families and communities of America. This has been particularly true for those who live in communities of color. One unintended but dreadful consequence of the War on Drugs is that it has created a profoundly punitive culture that actually supports and encourages relapse and a return to addiction.

As we have seen, identity transformation is central to long-term recovery. When we ban or make it difficult for those with a drug conviction to get federal financial aid for education, we are hindering their attempts at developing new identities.

When high school students test positive for drugs, they are sometimes removed from athletic teams or suspended from school. From an identity perspective, this is the complete opposite of what is advisable. While there should be some kind of clinical evaluation to assess whether there is a drug or mental health issue, or if there is a medical problem that warrants attention, the goal should be to keep them socially integrated—to make sure that they stay on the team and that they keep attending school. To do otherwise is to increase the risk of dislocation.

The Ban the Box Movement is an effort to remove the question about whether an applicant has ever been convicted of a crime from the job application. For those who have been convicted of drug-law violations, asking that question makes it much more difficult for them to get employment.

All of these actions, which are fundamentally punitive in nature, put the individual at much greater risk of returning to the use of substances and, quite likely, an involvement with criminal activities. Clearly, the creation and affirmation of a new ethos in which we value all American lives would be a cultural shift of great importance and impact.

It is my hope, then, that we will choose the path of complexity, that we will choose the path of biopsychosocial liberation as we create the next generation of addiction treatments.

With love, science and art, may we continue to work for the liberation of those who are trapped in the prison of addiction.

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ⁱAlthough it is out of fashion in some circles, I have consciously and purposefully used the term “Addiction” in this essay. Addiction to alcohol and drugs is one of the great scourges on planet Earth – bringing sickness, poverty, violence, chaos, grief, anguish, crime, and death. For the drugs that were most commonly used in the United States – alcohol, tobacco, heroin, cocaine, and marijuana – the likelihood of becoming addicted if you try them once is [10-20 percent](#). In addition, there is a treatment aphorism that for every person who is addicted, four people will be immediately affected. I believe that there is some truth to this. In the face of this ocean of suffering, I feel that we frequently trivialize the devastating and tragic effects of terribly problematic substance use. Saying that all people are drug users and that many people use substances without deleterious consequences is unhelpful because it is diagnostically

unsophisticated. Once again, we are faced with the 80:20 phenomenon: 80 percent could probably benefit from drug education and some harm reduction interventions; the other 20 percent need the kind of complex interventions that I have laid out in this paper.

Given that, how do we know when someone is addicted? Addiction is best understood on a continuum. I would say that the addiction experience probably begins when an individual starts meeting 4 out of the 11 [DSM-5 Criteria for Alcohol or Substance Use Disorder](#); it would be more intensely experienced by those making criteria for the Severe range or 6 or more criteria. It is my hope that we will continue to use the DSM-5 criteria in our future discussions as it adds both clarity and light.

ⁱⁱ Subsequently, of course, both heroin and hydromorphone have been used as maintenance drugs with positive health outcomes. But the medical search—one that is particularly relevant to the idea of liberation—has been for longer-acting solutions.

Methadone was the best medication found by Dr. Dole's team because it was much longer-acting than heroin—24 versus 8 hours. Today, buprenorphine is better than methadone because it is even longer-acting—48 to 72 hours.

The challenge of heroin maintenance is how it is used. When I visited the heroin maintenance program in Geneva, I found a few things that I did not expect. First, patients had to come to the clinic twice per day to get their heroin injection. This would not, in my opinion, be a freedom-supporting option. Second, the heroin maintenance patients there were higher-functioning, not lower-functioning than the methadone patients. This was because they had to have the self-organization to actually get to the clinic two times per day within clinic hours.

In terms of freedom, giving people a prescription so that they can inject themselves at home would be better than the clinic situation. Nonetheless, consider whether it is ultimately preferable to take a medication once every eight hours or once every two or three days. While I am aware of the data showing that providing heroin maintenance has good outcomes, I do doubt that people will want to be on it for a long time or that it will be a successful maintenance medication for large numbers of people.