The Bio Psycho Social Spiritual (BPSS) Model of Addiction

People differ in the way they cope with all kinds of problems in their lives. Everyone has a specific view of the exact nature and characteristics any problem they come across. The same applies to the problem of addiction. Below, we will talk about a number of such perspectives.

What History says about addiction

Historically, there have been different views about the exact essence (the origin, nature) of the addiction problem (*see table 1*).[1] As a result, addiction has been dealt with in many different ways over the years.

A) At first, addiction was primarily seen as a moral weakness: ***the moral model***. The addict (someone who is often drunk) is weak and immoral, i.e. morally wrong. A Christian version of this model is to see addiction as sin.

According to this view, people can make moral choices but decide on the immoral path. The solution for the addiction problem within this paradigm was sought in prison or a re-education camp. Though the view of addiction has been a-moralized (not moral nor immoral) over the last couple of centuries, there are still people who agree with this model today.

B) With the rise of medical science in the second half of the 19th century, the addictive *substance* was gradually seen as the main cause for addiction: ***the pharmacological model***. According to this model, the source of the acction problem was the substance, not the person. The solution for the addiction problem was now sought in prohibiting the addictive substance. By prohibiting the addictive substance, it would not be readily available.

C) In the 1930's, another model came up: it emphasized that addiction was a symptom of deeper underlying personality or character problems. Those problems needed to be addressed by psychotherapy: ***the symptomatic model***. Here, the addict suffers from a personality disorder. In therapeutic communities, psychotherapy was seen as the appropriate solution, aiming at furthering the addicted person's self-awareness.

D) In the period since the 1940's, ***a disease model*** gained popularity: because of their biological and psychological profiles, some percentage of the population would be much more vulnerable for addiction in comparison with the majority (not-addicted persons). This model propsed that these people are simply not capable of using drugs and alcohol moderately. Addiction is described in terms of loss of control and physical dependence (E.g. 'tolerance' and 'withdrawal symptoms'). The solution is seen in lifelong abstinence, for example via self-help organizations.

1 The historical overview has been based on (Van den Brink, 2006)

E) From the 1960's another model was added: ***the learn theoretical model***. Basic to this perspective is that behavior that has been learned, can also be 'un-learned', including addictive behavior. The therapeutic approach is here in the form of cognitive behavioral therapy and cue-exposure therapy.

Multi-aspect models

What the addiction models mentioned above have in common, is that the focus is on *one aspect* that seems to be the most important one in explaining the addiction problem. But in the 1970's and 80's, people started to acknowledge that if we restricted the explanation of addiction to just one of its aspects, that doesn't do justice to the *multidimensional* nature of addiction.

This concept of a 'multi-dimensionality of addiction' meant an adjustment – even correction – of the one-dimensional approaches that had been prevalent up till then. Researchers and treatment providers alike realized that in order to gain a more truthful, more integrated picture of addiction, *all* relevant aspects of addiction should be taken into account simultaneously.

Apart from biological and psychological causes, social circumstances also play a key role in the development of an addiction. This led to a ***bio-psycho-social model of addiction***, a model that is still prevalent today. This model says: for the development of an addiction, there cannot be just one root cause. Different factors: at the biological level (i.e. genetic predisposition), the psychological level (i.e. dysfunctional thoughts and behaviors) as well as at the social level (i.e. disturbed relationships, problems with housing) determine whether someone becomes addicted or not. To address the addiction problem we need to take into account all these levels via multimodal (integrated) interventions.

However, since the 1990's some have returned to a much more one-dimensional approach of addiction: addiction as being primarily a brain disease I.e. *the brain disease model*. Research into addiction now predominantly consists of brain research.

Table 1: Short history of the concept of addiction

Period	Dominant addiction model	Treatment
1750	Moral model	Prison, re-education camp
1850	Pharmacological model	Prohibition of alcohol and drugs
1930	Symptomatic model	Psychotherapy en therapeutic communities
1940	Disease model	Medication and AA
1960	Learn theoretical model	(Cognitive) behavioral therapy
1970	Bio-psycho-social model	Multi-modal therapy
1990	Brain disease model	Medication and (cognitive) behavioral therapy

Bio-psycho-social-spiritual model of addiction (BPSS)

But is addiction predominantly a bio-medical problem? A chronic relapsing brain disease?

This question is far from being settled. Even a bio-psycho-social model – though broader – still leaves out a category of great importance in the addiction problem: the spiritual. In scientific literature, there are many perspectives, each of which provides, legitimate, although, limited views of what constitutes addiction. Emphasizing specific aspects of addiction and neglecting others may hamper an integral, comprehensive , "Holisic" view of addiction.

Addiction is a phenomenon concerning the *whole* person, not just the bio-medical, psychological or social aspects of this person. Addiction is a problem that at the very least is also defined by existential dependency and by life problems, by detachment, disengagement, being broken from the moorings, in short, by 'existential dislocation'.

In other words, addressing addiction means that some key questions about the purpose of human existence need to be thought through. For example: Why are we here? Why should I experience pain? Why not purely pursue pleasure as the highest purpose of life? In the end, addiction is a problem of the heart, in the Biblical sense of the word. As someone has written: "The addict has a problem, but it is not a medical one, it is an existential, spiritual one: he does not know how to live." And when addiction is not a medical problem, medical interventions will not solve it. Addicts will have to be given a reason for living. They need to have a meaning for life.

A BPSS-model goes beyond the medical, the moralistic and the punitive. In it, every human being is accepted as being created in the image of God. It deals with him on the basis of grace and truth. The model acknowledges the human inclination to evil and does not reduce the addiction problem – or any other problem – to societal structures. It takes into account that, as Martin Buber says, God has been eclipsed from the human horizon. This now means that mere man has become the measure of all things.

Dealing with addiction is, dealing with the problem of 'belonging'. When we stop talking about meaning and purpose, at best we will arrive at superficial solutions that do not do justice to what a human being is. In a *bio-psycho-social-spiritual model of addiction* these deeper issues can be dealt with. Spirituality needs to be included as a factor in the understanding and treatment of addictive behaviors.

In the BPSS model, addiction is concerned with the way in which relationships break down by making a particular substance or behavior an object of desire for its own sake. In that sense, addiction is not something alien to any of us. Addiction has to do with divisions of the will, with wanting to continue drug use despite also wanting to discontinue. Within a *bio-psycho-social-spiritual model of addiction* there is room for recognizing the sin in addiction as well as, at the same time, the need for grace to set people free from captivity. And at the same time, there is full recognition of the equally relevant bio-medical, psychological and social aspects of the problem. But all these aspects find their center in the *heart* of the person. The heart is where he/she has to decide to what to give ultimate commitment to.