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PAUL DAVIS, ROBERT PATTON AND
SUE JACKSON

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Addiction: Psychology and Treatment

EDITED BY

PAUL DAVIS
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This edition first published 2018
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Library of Congress Cataloging-in-Publication Data
hardback: 9781118489741
paperback: 9781118489758

Cover image: © Max Krasnov/Shutterstock
Cover design by Wiley
Set in 11/12.5pt Dante MT Std by Aptara Inc., New Delhi, India

10 9 8 7 6 5 4 3 2 1

Table of Contents

List of Contributors xi
Foreword xiii
Preface xvii
Notes on Contributors xix

PART 1 Understanding the Psychology and Treatment of Addictions 1

CHAPTER 1 Addiction: A Comprehensive Approach 3
Jamie Brown and Robert West

1.1 Introduction 4
1.2 Existing theories 5
1.3 The human motivational system 8
1.4 Internal and external sources of influence 11
1.5 The dynamics of the system 12
1.6 Changing dispositions 14
1.7 Testing the theory 15
Suggestions for further reading 16
References 16

CHAPTER 2 An Attachment-Informed Approach to Working with Addiction 20
David Curran and Mani Mehdikhani

2.1 Introduction to attachment 21
2.2 Attachment and psychopathology 23
2.3 Attachment and addiction 25
2.4 Attachment styles in clinical samples 28
2.5 Assessment and formulation through an attachment lens 29
2.6 Treatment implications 32
2.7 Conclusion 35
Suggestions for further reading 35
References 36

CHAPTER 3 Families, Friends and Addiction: Impacts, Psychological Models and Interventions 42
Alex Copello and Kathryn Walsh

3.1 Introduction 43

3.2 The composition of alcohol and drug users' social networks 43
3.3 Impacts of addictions on others 44
3.4 Theoretical models of addiction and the family: stress-strain-coping-support 47
3.5 From models to interventions 48
3.6 Conclusion 52
Suggestions for further reading 53
References 54

CHAPTER 4 Working Systemically with Alcohol Misuse 57
Arlene Vetere and Rudi Dallos

4.1 Introduction 58
4.2 Family life 59
4.3 Family systems approaches 60
4.4 Working therapeutically with violence and abuse 64
4.5 Engagement and the therapeutic relationship 65
4.6 Conclusion 66
Suggestions for further reading 66
References 67

CHAPTER 5 'Dangerous Desires and Inanimate Attachments': Modern Psychodynamic Approaches to Substance Misuse 68
Martin Weegmann and Edward J. Khantzian

5.1 Introduction 69
5.2 Primitive emotional states: Kleinian views 70
5.3 Comforting self-objects: Kohutian views 72
5.4 Inanimate attachments: Bowlbian views 74
5.5 Bringing it together: addiction as a disorder of self-regulation 76
5.6 Reflective practice 78
5.7 Internal recovery 79
5.8 Conclusion 81
Suggestions for further reading 82
References 82

CHAPTER 6 Mindfulness, Acceptance and Values in Substance Misuse Services 84
Liz McGrath and Dominic O'Ryan

6.1 Introduction: what are the principles and methods of mindfulness, acceptance and values? 85
6.2 How does ACT integrate with other approaches? 87
6.3 How does the service use these principles and methods of ACT? 90

6.4 How do mindfulness, acceptance and values support the resilience of staff in the face of seemingly relentless relapse and other behaviours? 92
6.5 What are the experiences of staff working with ACT? 94
6.6 What are the experiences of clients working this way? 96
6.7 Our experience of ACT 97
Suggestions for further reading 98
References 98

PART 2 Clinical Applications of Addiction Psychology 103

CHAPTER 7 The Role of Clinical Psychology within Alcohol Related Brain Damage 105
Fraser Morrison and Jenny Svanberg

7.1 Introduction 106
7.2 Clinical definition of alcohol-related brain damage and related syndromes 106
7.3 Epidemiology of ARBD and related syndromes 107
7.4 Cognitive function in ARBD 108
7.5 Psychosocial and cognitive rehabilitation 111
7.6 Legal framework: mental capacity 117
7.7 Recovery 118
Suggestions for further reading 119
References 119

CHAPTER 8 Trauma and Addiction 124
David Curran

8.1 Psychological trauma and PTSD 125
8.2 The relationship between addiction and psychological trauma 127
8.3 Assessment 129
8.4 Treatment of co-existing trauma and substance use disorders 131
8.5 Clinical implications 135
8.6 Conclusion 139
Suggestions for further reading 139
References 139

CHAPTER 9 Narrative Identity and Change: Addiction and Recovery 144
Martin Weegmann

9.1 Narrative theory 145
9.2 Narrative therapy 145

9.3 Narrative theory and addiction 146
9.4 Client talk 147
9.5 Generating narrative 149
9.6 Narratives of recovery 152
9.7 Varieties of recovery story 152
9.8 Conclusion 154
Acknowledgements 155
Notes 155
Suggestions for further reading 155
References 156

CHAPTER 10 Addiction and Mental Health 158
Adam Huxley

10.1 Introduction 159
10.2 Association between substance misuse and psychosis 160
10.3 Prevalence and epidemiology 162
10.4 Outcomes associated with co-occurring disorders 163
10.5 Treatment approach and effectiveness 163
10.6 Evidence for effectiveness 164
10.7 Conclusion 166
Suggestions for further reading 167
References 167

CHAPTER 11 Substance Misuse in Older Adults 172
Sarah Wadd and Tony Rao

11.1 Introduction 173
11.2 Definition of older adult 173
11.3 Alcohol 173
11.4 Illicit drug use 176
11.5 Medication misuse 178
11.6 Assessment of older people with substance misuse 179
11.7 Psychosocial interventions 184
11.8 Legal and ethical considerations 185
11.9 Using and evaluating health and social outcomes 186
11.10 Conclusion 187
Suggestions for further reading 188
References 188

CHAPTER 12 Issues Arising in Hepatitis C Work: The Role of the Clinical Psychologist 193
Jo M. Nicholson

12.1 Introduction 194
12.2 Hepatitis C background: the virus and treatment 194
12.3 Social and clinical characteristics of the HCV patient population 195

12.4 HCV treatment challenges 196
12.5 Pegylated Interferon-related adverse psychiatric side-effects 197
12.6 HCV-infected mental health populations 198
12.7 So what is the role of the psychologist? 200
12.8 Psychological stepped-care model in HCV treatment 206
12.9 Future challenge 208
12.10 Conclusion 208
Suggestions for further reading 209
References 209

CHAPTER 13 The Psychology and Treatment of Gambling Disorders 213
André Geel, Rebecca Fisher, and Aska Matsunaga

13.1 Introduction 214
13.2 Definition 214
13.3 Prevalence 215
13.4 Demographic risk factors 216
13.5 Treatment of gambling disorders 222
13.6 Personal comment and reflections 224
13.7 Conclusion 224
Suggestions for further reading 225
References 225

CHAPTER 14 Alcoholics Anonymous and 12 Step Therapy: A Psychologist's View 230
Martin Weegmann

14.1 Introduction: personal context 231
14.2 History 232
14.3 Philosophy 233
14.4 How does it work? 235
14.5 What can psychologist and helping professionals do? 239
14.6 Criticisms of AA 240
14.7 Postscript 241
Notes 241
Suggestions for further reading 242
References 242

CHAPTER 15 Relapse Prevention: Underlying Assumptions and Current Thinking 245
Robert Hill and Jennifer Harris

15.1 Introduction 246
15.2 What is relapse prevention? 246
15.3 Models of relapse prevention 250
15.4 Addressing co-existing mental health 254

15.5 Neuropsychological and associated difficulties when undertaking RP 255
15.6 Conclusion 257
Suggestions for further reading 258
References 259

CHAPTER 16 Working with Ambivalence about Change: Motivational Interviewing 262
Lisa Dutheil and Alina Galis

16.1 Introduction 263
16.2 Definition 263
16.3 Historical perspective 264
16.4 Theoretical influences 265
16.5 The spirit of MI 266
16.6 Change talk, sustain talk and discord 266
16.7 The four MI processes 267
16.8 Core MI skills 269
16.9 MI strategies more specific to particular processes 271
16.10 Evidence for the efficacy of MI 272
16.11 Integrating MI with other approaches 274
16.12 Using MI in groups 275
16.13 Learning MI 277
16.14 Conclusion 278
Suggestions for further reading 279
References 279

CHAPTER 17 'Beyond Workshops': Turning Evidence for Psychosocial Interventions into Embedded Practice 284
Luke Mitcheson, Christopher Whiteley, and Robert Hill

17.1 Introduction 285
17.2 What is implementation? 285
17.3 Implementation science 287
17.4 Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) 287
17.5 Implement what? Evidence-based interventions versus evidence-based practices 292
17.6 Case studies in Motivational Interviewing and treatment effectiveness (Mapping) 294
17.7 Conclusion 298
Notes 300
Suggestions for further reading 300
References 300

Index 303

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Foreword

Addiction is highly prevalent. The World Health Organization (WHO) estimates that the number of people globally who suffer from an alcohol or drug use disorder annually is in the region of 100 million. Harmful and hazardous alcohol use, like tobacco, is considered by WHO to be a major preventable contributor to the global burden of disease and disability. There is no estimate, to my knowledge, of the worldwide prevalence of gambling disorder, but in Britain alone the adult annual prevalence is in the region of a third to a half million, which is very similar to the prevalence of disorders associated with illicit drug use. So prevalent is addiction that it can reasonably be thought of, along with anxiety and/or depression, as one of the two most common forms of psychological disorder. Yet in most relevant professions and disciplines, including psychology, it remains strangely marginalized. In Chapter 14 in this volume, on AA and 12 Step programmes, Martin Weegmann admits that when he first worked in the area of the addictions he had had virtually no experience of this client group, and minimal training in the area during his clinical psychology course. My experience was even worse. I led two clinical psychology training courses, in Exeter for 17 years in the 1970s and 1980s, and then in Birmingham for five years in the 1990s. Despite my passionate interest in the addictions, the British Psychological Society requirements for a training course, plus the lack of availability of supervised practice, plus I suspect a lot of prejudice about the topic, meant that my success in giving trainees a better grounding in the subject than Martin and I had had was only minimally successful. Perhaps everything has changed. I hope so, but suspect not. That is one of the main reasons why this book is so important.

Judging by the enthusiasm shown by all the authors of the chapters of this book, it seems their experience of finding themselves working in the addiction field – like me, often by accident, I suspect – was of entering a field that is endlessly rewarding and fascinating. Large numbers of people overcome their addictions, often with our help and sometimes even without it, and when they do, their recoveries are frequently impressive, given the depths to which their lives have been harmed. Addiction has more than its share of sadness and despair, but it is also replete with hope and inspiration.

For all that we have learned about addiction and its treatment – including so much that is included in these chapters – there remains a great deal that is mysterious about it, and about recovery from it. The scope for researching and theorizing about addiction, for developing and evaluating forms of treatment, for applying knowledge and methods for understanding and treating such complications of addiction as brain damage or Hepatitis C – both topics accorded chapters here – is endless. In fact, no one book can explore anything like all the intriguing issues that surround addiction. How do gender roles influence the prevalence of the different forms of addiction?

What insights does psychology offer about how we might prevent addiction? What has psychology to say about what our relationships should be, if any, with the suppliers of the products to which people can become addicted – the commercial suppliers of alcohol, tobacco and gambling products and the legal and illegal suppliers of other substances? These are among the questions that must wait for a second edition.

This book treads dangerous ground in a number of ways, departing often from dominant thinking in the field. The latter is under the sway of a bio-psychological model of addiction which privileges diagnosis (very little mention of *DSM* can be found in this book), a rather limited approach to evidence-based treatment, and a greater emphasis on aggregated statistics than on a detailed understanding of the experiences of people who suffer from addiction and those others who are affected by it. Certain vital issues are neglected because of that dominant model of addiction, but they get proper attention here. One, which is repeatedly mentioned, is the importance for addiction of emotions and emotional regulation. This receives some attention in the dominant paradigm – the idea of self-medication, for example – but is rarely explored in any detail. Cognition tends to rule and emotion sits in second place. Emotions and emotional regulation have the great strength of being something that unites sub-topic areas such as attachment, psychodynamic and systemic approaches, and relapse prevention and mindfulness, albeit dealt with differently under those various headings.

There are chapters in this book which reach other parts of the mystery and despair of addiction which the dominant paradigm does not reach. One feature of addiction, rarely addressed elsewhere, is its effect on a person's ability to relate to others, variously described in different chapters as the replacement of affectional bonds by 'addictional bonds', empathic blunting, and the way addiction can interfere with sensitivities and capacities (see Nussbaum, 2000, a favourite book of mine, for an explication of the capabilities approach). Family members affected by their relatives' addictions, who are equally as numerous as those who experience addiction at first hand, and probably more so, often talk of how their relatives have ceased to be the people they knew and loved and how addiction seems to have robbed their relatives of the capacity to care for the family. For family members, addiction is truly a mystery – how can this person they knew be investing so much in something that seems so pointless and so damaging, and relatively less in what really matters? It is good, therefore, to see families highlighted early on in the book, and in more than one token chapter, as is often the case.

Another central feature, infrequently given the attention it deserves but properly addressed here, is the ambivalence and fragmentation that come with addiction (Adams, 2008). This can be seen as a surface phenomenon, as in the instability of motivation to change (an idea that West derives from PRIME theory), or the ambivalence which is central to motivational interviewing theory, or the conflict which is central to my Excessive Appetites model (Orford, 2001). But it can also be seen, as it is in a number of chapters, as a deeper fragmentation of the self. Rarely dealt with in psychology, one otherwise needs to go to the philosopher Levy (2011) for an appreciation of fragmentation of self as being close to the essence of addiction. His key idea was that an addicted person's preferences are inconsistent: the ability to make judgements about action is not impaired, but judgements shift from time to time. What

characterizes addiction, therefore, is the fragmentation of agency, an inability to consistently exert will across time, and the loss of full capacity to effectively make plans and put in place long-term projects. I see this as a form of disempowerment, and I found it extremely helpful in developing my attempt to use the concept of power to integrate otherwise disparate areas of addiction studies (Orford, 2013).

Yet another topic which it is good to see given attention is the importance for change and recovery of the relationship with helpers or therapists. As I put it in my article, 'Asking the right questions in the right way' (Orford, 2008):

> The prevailing model of psychological treatment for addiction can be described, aptly, as a technology model. It is likened to a technique which, supported by a manual and good training and supervision, can be delivered to a high standard so that 'therapist differences' cease to be important. The therapist is the medium through which a standard technique is applied at a high level of fidelity. Some have referred to this as the 'drug metaphor', implying that treatment is seen, like a medication, as a piece of technology that requires only therapist skill and efficiency and patient compliance in order to be delivered effectively.

Like the authors of some of the chapters in this book I have always been suspicious of that model, and our experiences in the UK Alcohol Treatment Trial (UKATT) confirmed my suspicions. When clients were asked at follow-up to what factors they attributed any positive changes they had made, the most popular attributions were characteristics of the therapist and of the client's relationship with the therapist, more so than social-type attributions for Social Behaviour and Network Therapy clients or motivational-type attributions for Motivational Enhancement Therapy clients (Orford et al., 2009).

I could go on listing the aspects of addiction which the conventional wisdom downplays or dismisses but which are not avoided in this highly thoughtful volume. The importance of narratives and story-telling, of personal and social identity, of one's life values, of the very meaning of life are among them. The experience of trauma and the high frequency of addiction problems combined with other mental health problems are recurring themes in the book.

However, clinical psychology faces a number of problems – although they are by no means confined to clinical psychology. One is the question of evidence. Like all professions, it is required to demonstrate that its treatments 'work'. That can be problematic, not just because showing that something works can be costly, time-consuming and fraught with methodological and interpretive difficulties – research evidence is often so complex that it is difficult to draw clear conclusions – but also because what constitutes main outcomes may be debatable. Is the main aim symptom relief or adjustment to symptoms; abstinence or harm minimization? It is also problematic if a treatment method is comparatively new and innovative. Acceptance and Commitment Therapy (ACT) is an example, as McGrath and O'Ryan's Chapter 6 makes clear. Is ACT an example of running ahead of the evidence, they ask, or is it even, as they say one client put it, just 'hocus-pocus'? Even if it can be demonstrated that a treatment works, there is the all-important question, addressed in the final chapter, of translating evidence into practice. This is a book about psychology being used to innovate, to push forward at the frontier of a subject that

needs new thinking and fresh solutions. It therefore takes us well beyond the safe and secure domain of cognitive behaviour therapy (although the point is made a number of times in this volume that new treatments can complement rather than replace existing ones).

There is, finally, another problem for psychological applications to the addictions, and that is the need to develop methods that can be applied to large numbers. Psychology has often been criticized on this score in the past. If its methods remain specialized, requiring lengthy training or specialized institutional infrastructure, then good will be done for small numbers but the impact on the huge problem of addiction will be limited. I have always agreed with the principle that psychology must be 'given away' if it is to be effective. We must think of training others who can deliver psychosocial treatments in non-specialized settings, or working remotely using modern communication technology. We must aim to make contact with hard-to-reach groups in our own countries, and the large numbers who might benefit from psychological methods in other countries, where specialized services and trained professionals are much thinner on the ground.

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Preface

Like many other complex health problems, addictions are probably best viewed within a biopsychosocial model (see, e.g. Ogden, 2012). It is, however, possibly a truism to say that the treatment of addiction is about changing behaviours, beliefs and feelings; something that psychology is likely to contribute to in a significant way. Understanding these processes from a psychological perspective, including using psychological approaches to recovery, is something academics and practitioners from all disciplines, professions and training backgrounds can benefit from. This book is intended to provide such an understanding and present an overview of the applications of psychology to addictive behaviours. The book is not written solely for psychologists, but rather is intended for all clinicians, practitioners and academics working in the addictions field, as well as those outside specialist services who may encounter addiction in their generic work. It brings together contributions from leading practitioners and academics in the addictions specialty, and provides in one volume a synthesis of psychological models and approaches used in this complex area.

Part 1 gives an overview of theories and models used to understand the aetiology and development of addictions and includes consideration of the psychological models used in the intervention approaches. Part 2 contains chapters on specific applications of psychology across selected addictive behaviour problems with a variety of service user groups, as well as practical guides to the implementation of addiction psychology in health and community care settings.

Many internationally recognized scientists, practitioners and experienced clinicians have contributed to this book, and we would like to thank them all. Gratitude is also expressed to the numerous service users who have informed the individual chapters; thank you.

REFERENCE

Ogden, J. (2012). *Health psychology: A textbook*. Maidenhead: Open University Press.

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FOREWORD

Jim Orford. In his time as a clinical, and later clinical-cum-community, psychologist working in NHS and university settings in London, Exeter and for the last 20 years in Birmingham, Jim Orford has researched and written extensively about substance and gambling problems and particularly about their impact on the family. His best-known work is *Excessive Appetites: A Psychological View of Addictions* (2nd ed., 2001) and his most recent book is *Power, Powerlessness and Addiction* (2013).

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Sarah Wadd is programme director of the Substance Misuse and Ageing Research Team (SMART) at the University of Bedfordshire and is one of the UK's leading experts on substance misuse in older people. Her seminal 'Working with Older Drinkers Study' identified best practice in this area, based on interviews with alcohol practitioners who specialize in working with older people and older people receiving alcohol treatment. She is an expert advisor on substance misuse in older people for the Welsh Government and the UK's Advisory Council on Drug Misuse. Sarah is the academic lead for the £25m Big Lottery-funded 'Drink Wise Age Well' Programme which aims to reduce alcohol-related harm in people aged 50 and over. Her other research studies have included alcohol misuse that co-exists with cognitive impairment in older people and illicit drug and medication misuse in older people, and she has contributed to studies on alcohol-related elder abuse and sight loss. Sarah is a cofounder of the Coalition of Older Adults Affected by Substance Misuse (COAASM), whose members work to reduce discrimination and improve prevention, services and treatment for older adults and families affected by substance misuse.

Kathryn Walsh is currently pursuing clinical psychology doctoral training at the University of Birmingham. Kathryn previously worked as a Research Associate at the School of Psychology, University of Birmingham, in a Brief Intervention National Institute of Health Research funded randomized controlled trial for people with addictions and severe mental health problems. She has published in the area of addictions and mental health and was awarded the first prize in the mental-health and substance-use essay competition 2012 by the *Mental Health and Substance Use* academic journal, where the essay was subsequently published.

Martin Weegmann is a consultant clinical psychologist and group analyst, with 20 years experience in the field of substance misuse. He is a well-known trainer, having delivered workshops and keynote lectures to a range of organizations through the United Kingdom, including organizing seven annual conferences on the theme 'Psychotherapy of Addiction'. Martin has co-edited two books, *Psychodynamics of Addiction* (2002, Wiley) and *Group Psychotherapy and Addiction* (2004, Wiley) and published many chapters and papers. His latest book, *The World within the Group: Developing Theory for Group Analysis* (London, Karnac) was published in 2014. In 2011, he joined the General Services Board of Alcoholics Anonymous, as a 'non-alcoholic trustee'.

Robert West is Professor of Health Psychology and Director of Tobacco Studies at the Cancer Research UK Health Behaviour Research Centre, University College London, UK. Professor West is also Editor-in-Chief of the journal *Addiction*. He has authored more than 500 scientific articles, books and book chapters. He was co-founder of the

NHS stop-smoking services. His research includes evaluations of methods of helping smokers to stop and population surveys of smoking and smoking cessation patterns. He is author of *The SmokeFreeFormula* (Orion), which aims to bring the science of stopping to smokers. For more information, see www.rjwest.co.uk.

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PART 1

Understanding the Psychology and Treatment of Addictions

1 Addiction: A Comprehensive Approach

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CHAPTER OUTLINE

1.1 INTRODUCTION 4

1.2 EXISTING THEORIES 5

1.3 THE HUMAN MOTIVATIONAL SYSTEM 8

1.4 INTERNAL AND EXTERNAL SOURCES OF INFLUENCE 11

1.5 THE DYNAMICS OF THE SYSTEM 12

1.6 CHANGING DISPOSITIONS 14

1.7 TESTING THE THEORY 15

SUGGESTIONS FOR FURTHER READING 16

REFERENCES 16

1.1 INTRODUCTION

'Addiction' is a social construct which can be usefully defined as a chronic condition in which there is a repeated powerful motivation to engage in a rewarding behaviour, acquired as a result of engaging in that behaviour, that has significant potential for unintended harm. From this perspective, a broad conception of motivation is at the heart of addiction and requires any theory of addiction to be based on a comprehensive theory of motivation. This approach understands addiction can be driven by many different factors – physiological, psychological, environmental and social – and that it is not useful to focus on one particular factor to the exclusion of all others. PRIME theory aims to provide a conceptual framework within which the major insights provided by more specific theories of choice, self-control, habits, emotions and drives can be integrated.

PRIME theory describes the motivational system as the set of brain processes that energize and direct our actions. The system can be usefully divided into five interacting but distinct sub-systems: (1) response execution; (2) impulses/inhibition; (3) motives (wants and needs); (4) evaluations (beliefs about what is good or bad); and (5) plans (self-conscious intentions). The response execution system co-ordinates what is happening at any given moment. The proximal influences on this are the impulses and inhibitions to perform particular responses. Motives can influence behaviour only through impulses and inhibitions, evaluations can do so only through motives, and plans must operate on either motives or evaluations. These can also each be influenced by the immediate internal or external environment. Important internal sources of influence include identity, self-control, drives and emotional states.

A core proposition is that all the subsystems compete with one another and we simply act in response to the strongest influence at any given moment. In terms of deliberate action, this means that from one moment to the next *we will always act in pursuit of what we most want or need at that moment*. These motives vary according to the current strength of evaluations and plans, but also in response to the internal and external environment. For example, if an intention or belief is not currently generating a sufficiently strong motive for performing (or inhibiting) a particular action, then the system may produce an apparently contradictory action in response to a strong internal drive or external stimulus. The operation of this dynamic, complex system is inherently unstable – reflecting the variety in patterns of addictive behaviour – and requires constant balancing to avoid heading into maladaptive 'chreods'. The motivational system can be changed over time by a range of processes including habituation, associative learning, imitation and explicit memory.

This chapter provide a brief background to the origins of PRIME theory, before describing in more detail the proposed structure of the motivational system, important internal and external sources of influence, the dynamics of the system, and how motivational dispositions change over time. The chapter will finish by summarizing addiction research that has been inspired and informed by PRIME theory.