

Support Groups and Treatment Groups Compare and Contrast Assignment

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Author Note

I have no known conflict of interest to disclose.

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Abstract

Treatment for addiction can look different for every individual seeking support. Relevant options include support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, and clinical therapy (treatment) groups. Support groups are spiritually based, while therapy groups are more clinically based. After the introduction, the histories and structure of AA, NA, and AlAnon groups are discussed. Then, the history and functions of addiction therapy groups are reviewed in detail. Psychoeducation groups, cognitive-behavioral groups, and dialectical behavior therapy (DBT) groups are specifically reviewed. The next major sections compare and contrast these two major group options/modalities. The conclusion includes personal notes and practice implications from the author.

Keywords: Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, clinical therapy groups

Introduction

The treatment of addiction is a highly individualized process. Group intervention for individuals struggling with a substance use disorder (SUD) and/or addiction can be both effective and efficient in developing healthy coping skills, increasing treatment engagement, and supporting recovery overall (Substance Abuse and Mental Health Services Administration, 2021). Other therapeutic advantages include the reduction of stigma and isolation through fostering social supports and developing meaningful communication and interpersonal relationships (Substance Abuse and Mental Health Services Administration, 2021).

Various types of group interventions exist. Support groups for addiction include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon. These groups are often peer led and spiritually based. Another support group modality is clinical therapy. These groups require clinical supervision and formal training, and they can be utilized in both inpatient and outpatient treatment settings (Substance Abuse and Mental Health Services Administration, 2021).

Prior to this assignment, the author attended virtual AA, NA, and Al-Anon meetings (three total). The experience of being an observer of each type of meeting allowed for the author to personally explore the experience of addiction support groups and learn how/why they can aid in fostering change. The purpose of this assignment is to expand beyond personal experience by integrating scholarly sources and academic knowledge. The first section reviews the history of the three types of support groups in depth and then details meeting structure and function. The same information is then covered for clinical addiction therapy groups. After the foundational knowledge is covered and a complete picture of each group setting is given, they are compared

and contrasted. While both modalities have functional differences, they each have unique strengths that allow them to be a successful tool in treatment and healing.

Support Groups

Addiction support groups include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon. While rooted in the same foundational beliefs, the various types of support groups for addiction have different histories. Their length of existence, important figures, and milestone developments all vary slightly. Present day status, goals, and future directions depend on the type of support group, making this knowledge foundational for participants and practitioners.

Brief History of Support Groups

Alcoholics Anonymous (AA)

While AA was founded on June 10, 1935, by Bill Wilson and Dr. Robert (Bob) Smith, the root of AA dates back to the late 1920s when Carl Jung refused to treat a patient, Rowland Hazard, after he fell back into the addictive cycle of alcoholism post treatment (White & Kurtz, 2008). Jung insisted that Hazard replace the craving for alcohol with a spiritual or religious experience (White & Kurtz, 2008). Thus, the foundational belief of AA- that there is a void that can truly only be fulfilled by God- was formulated. Bill, who was recruited by Rowland Hazard to join in this type of healing, and Dr. Bob met one another and soon discovered how helping others through their addiction allowed them to grow in their own recovery process (White & Kurtz, 2008). AA is rooted in the Oxford Group's teaching of spirituality and helped inspire the development of the AA Twelve Steps. Despite the group needing some refinement and developmental improvements, the 1939 publication of the *AA Big Book* allowed for the principles of AA to expand to others (White & Kurtz, 2008). From there, the AA has grown into

a worldwide organization and fellowship that focuses on the protection of its members through anonymity.

The Big Book is still a tool used in AA meetings today, as well as the *Twelve Steps and Twelve Traditions Book*. The 12 Steps and Traditions of AA are the key foundational principles of the organization and have allowed for those struggling with alcoholism to find purpose in their pain and give specific steps for overcoming addiction. AA aims to unify members through their aspirations to achieve sobriety. In the present day, AA has positively impacted long-term recovery for participants, as it promotes a support network that allows participants to grow in their spirituality, ability to be in the present, acceptance, self-esteem, and fellowship (McInerney et al., 2021). Even today, the goal and future direction of AA remains the same- recovery from alcoholism (Alcoholics Anonymous World Services, 2022). Especially since the COVID-19 pandemic, AA has allowed participants to continue to find therapeutic outlets in various forms, such as online meetings. Virtual AA meetings can be a viable option for those who are shy or anxious about recovery, which can help prevent premature termination of recovery practices (Di Carlo et al., 2022).

Narcotics Anonymous (NA)

Shortly after the establishment and success of AA, the role of mutual support in recovery expanded beyond those struggling with alcoholism. The AA program and belief principles were applied in a prison hospital- The United States Public Health Service Hospital in Lexington, Kentucky- to a treatment program for those struggling with narcotics (Lewis, 2017). As the application of AA principles were applied to populations struggling with opiate addiction, the frame of focus widened. AA responded to the extension by publishing articles that addressed applying the framework to narcotics, sedatives, tranquilizers, amphetamines, and drug use in general (Lewis,

2017). AA groups within prisons had increased in popularity through the 1940s and 1950s (Lewis, 2017).

A man recognized as Houston S. recognized the need for support groups to focus on the treatment of drugs overall rather than alcohol. Houston S. held Addicts Anonymous meetings within The United States Public Health Service Hospital in Lexington from 1947 to 1966 (Lewis, 2017). As these meetings grew in popularity, they began taking place throughout the nation. In 1949, a man known as Danny C. renamed these meetings to Narcotics Anonymous (NA), to avoid confusion between Alcoholics Anonymous (AA) and Addicts Anonymous (Lewis, 2017). In the early days of program development, NA was not widely supported. It wasn't until 1953 that NA was officially established by Jimmy Kinnon as president (Lewis, 2017).

Similar to AA, online/remote meetings became popular in 2020 due to the restrictions of the COVID-19 pandemic. A Zoom-based website that offers 24/7 NA meetings was created to offer continuous access to meetings (Galanter et al., 2024). Even with a new platform, the goal remains to sustain abstinence and promote recovery from drugs and SUDs (Galanter et al., 2024). The availability of meetings 24/7 offers a novel type of comfort, as it gives those struggling immediate support, as well as increased community and treatment access (Galanter et al., 2024).

Al-Anon

Similar to the establishment of NA, Al-Anon has close ties with the formulation of AA. The 1939 *AA Big Book* publication included a chapter that addressed wives of alcoholics, which showcased that there was an effect on the mesosystem (immediate environment) of the one struggling with addiction and/or alcoholism (Timko et al., 2012). During early meetings of AA, it was not uncommon for family members to meet together nearby at the same time (Timko et al., 2012). Al-Anon was formally founded in 1951 by Bill Wilson (co-founder of AA) and a woman known as Anne B others (Timko et al., 2012). Like the other two support group types,

the core beliefs of Al-Anon focus on the AA 12 Steps but shift the focus from self to others (Timko et al., 2012). *The Al-Anon Family Groups* book was first published in 1955, and then the Al-Anon 12 traditions were accepted in 1961 (Timko et al., 2012). Alateen, a subset of Al-Anon meant for teenage children of alcoholics, was founded in 1957 (Timko et al., 2012).

Present day, one out of five adults (approximately 25%) have experienced harm or negative effects as a result of someone else's alcohol use and drinking habits (Nayak et al., 2019). Al-Anon meetings are typically open to anyone who is considered a "concerned other" (CO). Like the other support groups, Al-Anon meetings occur both virtually and in-person. According to the Al-Anon Family Group (n.d.), the primary goal of Al-Anon meetings is still to foster support to COs who have been affected in negative ways by someone else's drinking through sharing common experiences and applying the 12 Step principles. Engagement data from Al-Anon can be used to inform other intervention methodologies to support COs and those who have been harmed (Karriker-Jaffe et al., 2024).

Meeting Structure and Function

While the focuses and adhering populations of these support group meetings all differ slightly (AA: alcoholism, NA: addiction in general, and Al-Anon: support for those around addicts), they are all built on the same foundational ideas. All three support groups follow the same relative structure. Kelly & McCrady (2008) detail the relative structure of meetings, which begin with the preamble, readings of support group texts (Such as the *AA Big Book*, the Serenity Prayer, the 12 Steps and traditions, etc.), and scripted statements regarding anonymity and introductions. The facilitator (or "leader") of the meeting can read through all of these or, oftentimes, group members will volunteer. There are multitudes of each type of support group, and each have their own topic timeline and discussions. Different subgroups for specific

populations exist, too (Kelly & McCrady, 2008). Oftentimes, there is either a text to be reflected on or a message from a scheduled speaker. From there, the group has the opportunity to share their experiences, thoughts, stories, hardships, etc. one at a time. The meeting facilitator will often keep timers for those sharing to avoid a singular person utilizing more time during a meeting than another. The facilitator also ensures that the meeting is in alignment with the 12 Steps, ends on time, and recognizes anyone who has hit a sobriety milestone (Kelly & McCrady, 2008). These support meetings typically end with a moment of silence and the Serenity Prayer.

Another important component of these meetings is the belief that addicts are “powerless” to control their substance use (Mendola & Gibson, 2016). Success stories are rooted in the belief that individuals are successfully engaging the 12 Step model (Mendola & Gibson, 2016). Success is celebrated through participant support, as well as gathering sobriety timeline chips. As previously stated, success stories are often shared as guest speakers within meetings and experiences are aimed to foster meaningful conversation. The recovery process and its related success, as well as shortcomings, are viewed to happen one day at a time (Mendola & Gibson, 2016). Relapses are viewed as learning experiences rather than moral failures (Mendola & Gibson, 2016). Rather than reprimand, inclusion and social support are the approaches taken (Zhang et al, 2018).

Addiction Therapy Groups

As opposed to support groups, therapy groups are more clinical in nature. This modality of addiction group intervention is led by a trained counseling/mental health professional and often employs therapeutic techniques, elements of psychological theories, and evidence-based practices. There are various types of addiction therapy groups that have been shown to improve

outcomes with SUDs and addiction treatments, such as psychoeducational groups, cognitive-behavioral therapy (CBT) group models, and Dialectical Behavior Therapy (DBT) groups.

Brief History of Therapy Groups

The history of therapy groups as are closely tied with the expansion of psychological and counseling theories. Psychoeducation was utilized in the 1900s as the first treatment method and aimed to increase the knowledge of participants (McCambridge & Cunningham, 2014). The foundation of clinical psychotherapeutic groups began in 1931 with Jacob Moreno's development of psychodrama (Kuentzel et al., 2011). As the distinct subset of group counseling was growing, major counseling models- such as cognitive behavioral therapy in the 1960s- were being developed. In 1970, the revolutionary book *The Theory and Practice of Group Psychotherapy* by Irvin Yalom was published. This book detailed eleven core factors that improve the effectiveness of group therapy. L. C. Marsh, E. W. Lazell, Trigant Burrow, and Samuel Slavson also helped developed the practice of group therapy in the United States (Kuentzel et al., 2011).

While the origins of CBT, psychoeducation, and DBT differ in timelines, they all highlight that groups are a propelling source of persuasion, stabilization, and support (Substance Abuse and Mental Health Services Administration, 2005a). The origins of DBT therapy begin in the 1980s (Ward-Ciesielski et al., 2020). DBT group skills training was a major component of the clinical trials in 1987 (Ward-Ciesielski et al., 2020). In 2011, Watkins et al. published the Building Recovery by Improving Goals, Habits, and Thoughts (BRIGHT) study, which highlighted how group CBT was associated with less depressive symptoms and improved substance abuse outcomes in residential substance abuse facility.

Therapy Groups Meeting Structure and Function

While various types of clinical addiction groups differ on the basis of theoretical orientation and intended goals, there are some similarities that underline them. The addiction meeting process begins with the member selection process. In order to yield successful treatment, participants must be vetted and matched with the appropriate group (Substance Abuse and Mental Health Services Administration, 2021). This can be based on factors such as gender, culture, personality, interpersonal skills, current problems, etc. Other considerations for all group treatment formats are structure (agenda), format (number of meetings, length of time, open or closed format), setting, and group size (Substance Abuse and Mental Health Services Administration, 2021). Once the group is formed by a professional, the process of gaining consent (if applicable) and actually beginning the group meetings can begin.

Psychoeducational Groups

Psychoeducation groups operate with one main goal in mind- to expand participant knowledge and awareness about the consequences and effects (behavioral, medical, and psychological) of substance abuse (Substance Abuse and Mental Health Services Administration, 2005b). The group facilitator will typically engage the group in specific content through videos, lectures, and audios, as well as guide the following discussion. Leaders are responsible for demonstrating skills, having knowledge of basic group dynamics, and ability to implement basic counseling techniques (Substance Abuse and Mental Health Services Administration, 2005b). This type of addiction therapy group is highly structured, and group members are expected to engage with the presented material and be prepared to relate it to their own lives and experiences of substance abuse (Substance Abuse and Mental Health Services Administration, 2005b). Members are encouraged actively participate, which allows them to take responsibility for their

learning and healing process (abuse (Substance Abuse and Mental Health Services Administration, 2005b).

Cognitive-Behavioral Therapy (CBT) Groups

While cognitive-behavioral groups is an umbrella term for a wide range of formats, the main goal is to restructure cognitive patterns (Substance Abuse and Mental Health Services Administration, 2005b). In this type of theoretical model, it is believed that restructuring the cognitive processes within oneself then affects the feelings and behaviors that follow. By interrupting thinking patterns, previously held beliefs, and perceptions, positive behavior change can occur. The role of the facilitator in CBT-based groups is to maintain structure by fostering an environment that focuses on immediate problems and allows participants to develop a social network that supports abstinence (Substance Abuse and Mental Health Services Administration, 2005b). Clients are expected to engage with techniques commonly used in CBT such as problem solving, short-term and long-term goal setting, and monitoring feelings, thoughts, and behaviors (Substance Abuse and Mental Health Services Administration, 2005b).

Dialectical Behavior Therapy (DBT) Groups

The purpose of dialectical behavior therapy-based groups is to help participants replace maladaptive behaviors with goal-oriented behaviors (Cavicchioli et al., 2021). DBT groups focus on skills trainings, which address areas such as mindfulness, emotional regulation, interpersonal effectiveness, and distress tolerance (Cavicchioli et al., 2021). For substance use specially, there are five models that facilitators can follow that dictate their specific role. The group education model puts the facilitator in the role of an instructor (Cavicchioli et al., 2021). Recovery skills training models have facilitators teach both cognitive and behavioral skills to the group (Cavicchioli et al., 2021). The group process model relates therapeutic effects to the interactions

between group members and the leader (Cavicchioli et al., 2021). The check-in group model allows the facilitator to conduct brief individual treatment within the clinical group setting (Cavicchioli et al., 2021). The groups addressing other issues relevant to substance use model allows for the facilitator to address other relevant topics such as anger management or anxiety (Cavicchioli et al., 2021). The role of the participants changes depending on the model being followed, but appropriate group norms are expected to be respected and followed.

Compare and Contrast

Similarities

After reviewing the history, structures, and functions of various group interventions to help treat addiction and SUDs, it is clear that there is some overlap between them. While support groups and clinical therapy groups differ in the level of training necessary, content, and therapeutic techniques, they all have the same overarching goals. Support and recovery are hoping to be achieved. Both group modalities offer a space where individuals' behavior can be influenced by others through means of support and social pressure (Coco et al., 2019). Support groups and therapeutic groups both emphasize and heavily rely on the group dynamic. For those struggling with SUDs in particular, these group settings can foster meaningful interpersonal relationships, help members identify their psychological needs and communicate them in an effective way, as well as classifying maladaptive thoughts and behaviors (Coco et al., 2019). Both spaces give members a place to feel understood, talk openly about successes and setbacks, and reduce the feeling of being alone in one's struggles.

Both support groups and therapy groups also reinforce commitment to the recovery process by emphasizing the importance of attendance, routine, accountability, and confidentiality. Having a social presence can improve adherence to health behaviors through the

process of taking responsibility (Oussedik et al., 2019). While accountability is taken through various formats (sponsorship, therapist-led reflection, therapeutic techniques, challenging, etc.), it is a foundational concept in making meaningful change to promote recovery and abstinence. The characteristic of accountability has no associations or correlations with factors such as age, sex, race, and level of education (Oussedik et al., 2019). This is important for those in recovery from addiction, as it affects people from various demographics.

Differences

One of the biggest differences between support and treatment groups is the level of training that is required of the leader/facilitator/chairperson. For AA, NA, and Al-Anon groups, the chairperson is required to be a sober member of the organization, understand the 12 Steps and Traditions and their potential to influence recovery, exhibit leadership and communication skills, have experience in group/office/institutional affairs, and experience with service meetings (Online Intergroup of Alcoholics Anonymous, n.d.). Essentially, the leader of a support group must have personal experience with the process of AA, NA, and/or Al-Anon and feel confident in leading a group that upholds the traditions, values, and beliefs. For therapy groups, leadership requires a much more extensive list of qualifications such as licensure in mental health professions (counseling, social work, etc.). Oftentimes, facilitators of therapy addiction groups receive specialized training in group dynamics, modalities, techniques, stages, etc. on top of their graduate coursework and licensure requirements (Substance Abuse and Mental Health Services Administration, 2005b).

Another major difference between support and treatment groups for addiction is the process of participants becoming group members. For support groups, there are a multitude of open meetings for AA, NA, and Al-Anon. An open meeting means anyone can attend and

newcomers are always welcome, even if it is just to observe. A closed meeting, in the context of support groups, are only for AA/NA/Al-Anon members or those who have a substance use problem and have a desire to stop using. Even if a meeting is closed, newcomers are encouraged to join at any time. For treatment groups, as previously reviewed, group members are often selected by the chairperson or facilitator for specific reasons. The selection process of group members is influenced by the knowledge of group dynamics, the presenting issue, the overall goal of the group treatment sessions, resources, and availability (Substance Abuse and Mental Health Services Administration, 2005a).

Strengths and Limitations

Both of these group treatments offer different strengths and limitations. Support groups for addiction treatment are easily accessible for those looking for socio-communal aspects and a sense of relatability. Meetings are available globally through in-person and virtual formats at various hours of the day, making it a viable option for many seeking support with their recovery journey. The availability of open meetings allows for effective treatment practices to reach anyone who is curious about recovery. Closed meetings offer a safe space that heavily promotes recovery and reliance on a Higher Power (HP). However, despite the clinical and public health utility, effectiveness, and cost-effectiveness of these support groups (Kelly et al., 2024), there are limitations as well. Limitations of support groups include the emphasis on personal powerlessness, internalized pathologization, and the internal organizational view that it is the only solution for personal wellness (Glassman et al., 2023). The heavy emphasis on God, or one's personal HP, can be off-putting to some as well.

Clinical therapy groups for addiction offer evidence-based practices and techniques that have been heavily researched and proven to help in the treatment of addiction. Unlike support

groups, therapy groups place more of an emphasis on empowerment and self-efficacy in the recovery process, which allows participants to feel confident in their choices and decisions regarding abstinence or treatment goals (Kelly et al., 2024). Therapeutic groups tend to align with participants philosophical beliefs, as well (Kelly et al., 2024). Even with these strengths, though, limitations do exist. Therapeutic group treatment can be difficult to access and afford. On top of the barrier of accessibility, participants are often “chosen” for a specific group, which limits the chances of participation further.

Multi-Cultural Applications

Multi-cultural practices are becoming increasingly important in today’s field of addiction recovery and treatment. Between the two group modalities discussed, therapy addiction groups are more culturally sensitive. Cultural awareness, or the understanding that beliefs, values, practices, and experiences are not shared by everyone, is a pressing concern (Substance Abuse and Mental Health Services Administration, 2021). Professionals trained to conduct clinical group therapy are trained in skills such as body language, attention to gestures and touch, attention to microaggressions, barriers, and using culturally specific community resources (Substance Abuse and Mental Health Services Administration, 2021).

The heavy involvement of spirituality in support groups can make them feel intimidating and unwelcoming to some. However, this has been mitigated by the transition of allowing members to choose what or who their HP is. This breaks away from the religiosity, and more towards personal theology. Support groups have grown in inclusion, as they offer meetings for specific genders, races, LGBTQIA+ communities, etc.

Spiritual Aspects

As mentioned, spirituality is a key component in support groups. The Twelve Steps and Traditions all revolve around the belief in a HP. Specifically Steps 2-3, 5-7, and 11-12 highlight this. Other spiritual aspects of support groups include the serenity prayer, which is incorporated to most (if not all) meetings, and AA/NA/Al-Anon written texts and publications. Service to others is also a key component in support groups, which is supported by biblical scripture such as Romans 12:10, 1 Peter 4:10-11, and Galatians 5:13.

While not as common, spirituality can be incorporated into clinical therapy groups as well. In clinical work, aspects of spirituality must be handled with care to adhere to ethical codes. Different types of prayer- like mindfulness prayer, ritual prayer, and intercessory prayer- can be incorporated into addiction treatment practices (Sperry & Stoupas, 2018). Specific spiritual interventions, such as Bowen, Chawla, and Marlatt's mindfulness-based relapse prevention (MBRP), have been empirically examined. MBRP combines aspects of spirituality and CBT to aid in the addiction recovery process (Sperry & Stoupas, 2018).

Conclusion

Through the process of taking part in experiential research and reviewing published academic research, it was learned that the various group modalities and interventions can be an essential part of addiction recovery. The group experience fosters meaningful community, allows participants to learn from one another's experiences, and promotes accountability in the recovery process. For many, these groups are essential to recovery and maintenance of abstinence. Support groups and clinical treatment groups each offer specific benefits, as well as have their own limitations. One cannot be considered better than the other. Rather, the impact and success of each group is dependent on participant goals, perceptions, and personal beliefs.

In my future work/practice, I plan to utilize both support groups and therapy groups in treatment for my clients. I know that not all clients will be interested in group work, but it is important to have conversations about the potential benefits. Careful and considerate conversation about a client's interest in working with others can begin this process. Clients can utilize one or both types of group interventions. If clients show an interest in the incorporation of spirituality and the goal of abstinence, I would recommend support group involvement. I am not qualified to lead support groups myself, so I would recommend clients explore the available meetings that would suit their needs. If self-efficacy and more clinical approaches are favored, I would recommend clinical therapy groups. Depending on the need, I could lead one myself as a professional. If I know there are existing groups that align with client expectations and goals, I could refer the client to existing groups.

In conclusion, group work can be extremely impactful on participant's recovery from addiction and SUD. While group work can be complex, as many different dynamics are at play, participants find meaningful communities that support recovery and promote vicarious learning experiences. By understanding the different types of group interventions available, I can help guide my clients on their path of recovery that aligns with their readiness for change and their needs.

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Theoretical Models and Approaches Assignment

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Introduction

There are various models of addiction that aim to explain its etiology. Each model highlights different causes of substance use disorder (SUD) and addiction, as their foundational beliefs and focus on various influences differ. While professionals may align more with a specific model over another, no addiction model exists that encompasses a complete explanation behind addiction and SUDs. To better understand why some people become addicted while others do not, it is important to examine different approaches.

Model 1: Family Systems Model

Overview

The family systems model focuses on the interrelation of family members (Capuzzi & Stauffer, 2025). The impact of circular causality is emphasized (Nastasić, 2020). Because one's behavior is constantly being influenced by those around them, groups often create a set of "normal behavior" or sense of homeostasis. Patterns of circularity and homeostatic processes contribute to the formation and duration of addiction (Nastasić, 2020). This looks different for everyone and goes beyond family members using and abusing substances together. For example, as Capuzzi & Stauffer (2025) explain, if a family member experiencing a SUD shows interest in the recovery process, the homeostatic equilibrium would be thrown off- causing anxiety in other members.

Biblical Truths and Christian Principles

The impact of the company you keep is seen throughout the Bible. The story of Lot (Genesis 13, 18-19) highlights this. Due to his association with wickedness and immoral people, Lot and his family experienced severe distress and eventually fled the city. This highlights the impact of the people and environment around you (i.e., family systems). Proverbs 22:6 (ESV)

states, “Train up a child in the way he should go; even when he is old he will not depart from it.”

This reflects the patterns of circularity and homeostatic processes that are foundational to the family systems model of addiction.

Explanation of Addiction

This model provides a good explanation of addiction because it highlights the intersectionality of individuals’ lives. For decades, research has been concluding that behavior is shaped through the process of peer socialization and perceived norms (Henneberger et al., 2021). It has been found that intergenerational substance use, family support and strain, and peer support and/or pressure all can impact substance use trajectories (Jones et al., 2024). Because of all of these factors, it can be understood how behaviors related to SUDs are modeled. Often times, reactions from the family system either contribute to or deter these behaviors.

Model 2: Genetic Model

Overview

The genetic model of addiction falls under the biological category of addiction theory, and it proposes that some individuals are genetically predisposed to addiction and SUDs (Capuzzi & Stauffer, 2025). More specifically, individuals may inherit some sort of metabolic defect that can lead to alcoholism and other addictions when paired with specific environmental stimuli (Capuzzi & Stauffer, 2025). While the genetic architecture of an individual is not always the direct cause of substance use, a common genetic factor can partially explain individual susceptibility to alcohol, tobacco, cannabis, and opioid use disorder (Hatoum et al., 2022).

Biblical Truths and Christian Principles

In the Bible, human nature and the human body are described as a distinct creation of God (1 Corinthians 15:39). While the topic of genetic predisposition is not explicitly addressed,

it is suggested that consequences of sin that are passed down throughout generations. Romans 5:12-13 (ESV) states, “Therefore, just as sin came into the world through one man, and death through sin, and so death spread to all men because all sinned—for sin indeed was in the world before the law was given, but sin is not counted where there is no law.” All humans will fall short of the glory of God- sometimes through addiction- however, this leaves room for God’s grace and mercy.

Explanation of Addiction

Because the genetic model of addiction explains the biological factors and predispositions that can increase the risk of a SUD in an individual, it presents a clear methodology and allows for greater nuance in treatment. Genetic factors can play a role in behaviors like cravings (Capuzzi & Stauffer, 2025) and relapse (Ajodo et al., 2024). Changes in brain structure and function, as well as neurotransmitter and reward circuit activation, can impact addictive behaviors (Ajodo et al., 2024). Biological terms and processes can easily be conceptualized by the academic and scientific communities, allowing for personalized treatment methods.

Model 3: Cognitive-Behavioral Model

Overview

The cognitive-behavioral model of addiction, which falls under the psychological category, attempts to explain addiction through the lens of cognitive processes regarding motivation and reinforcement (both positive and negative) in an individual (Capuzzi & Stauffer, 2025). Using a substance positively reinforces the experience through rewards like physically enjoying the feeling, social acceptance, etc. Negative reinforcement may occur by taking away feelings of anxiety, sadness, discomfort, physical illness/withdrawal symptoms, etc. The

progression of cognitive processes (thoughts) influencing feelings and behaviors keep the addiction cycle in motion (Koob, 2022).

Biblical Truths and Christian Principles

The cognitive-behavioral model of addiction emphasizes the power of our thoughts produced by our minds. The human mind is a powerful tool in which God equipped humanity. However, like most things that hold power, the mind can influence us to engage in both positive and negative behaviors. Romans 12:2 (ESV) instructs believers by stating, “Do not be conformed to this world, but be transformed by the renewal of your mind, that by testing you may discern what is the will of God, what is good and acceptable and perfect.” This verse alone highlights many aspects that align with cognitive-behavioral model of addiction. Patterns of the world/flesh exist. However, there is hope in the renewal of our thoughts to overcome trials and tribulations through Jesus and His atonement on the cross.

Explanation of Addiction

This model of addiction offers a unique view that implicates one’s thoughts, feelings, and behaviors. The use of addictive substances can impair cognitive flexibility (Gangal et al., 2023). This explains addiction through physical properties of the brain (i.e., the inhibition of striatal cholinergic neurons), but then also connects these processes with psychological conditioning processes (Gangal et al., 2023). Reward pathways can be altered through craving immediate relief over larger delayed rewards (Acuff et al., 2023). This allows for treatment options to focus on the sequence of thought patterns, the feelings associated with them, and the related behaviors.

Model 4: Developmental Model

Overview

The developmental model of addiction emphasizes the roles of typical and compromised human development (Capuzzi & Stauffer, 2025). The overarching goal of the developmental model is to identify what factors increase or decrease the risk of engaging in substance use and addiction related behaviors (Capuzzi & Stauffer, 2025). Oftentimes, developmental models will assess the influence of adverse childhood experiences (ACEs), as they have been proven to be predictors of early use of alcohol, other drugs, problematic substance use, and addiction (Hays-Grudo et al., 2021).

Biblical Truths and Christian Principles

Throughout the Bible, there are stories that highlight the importance of community. ACEs include abuse, neglect, having family members who struggle with addiction, domestic violence, loss of a parent, etc. (Merrick et al., 2019). All of these reflect some sort of relational deficit. Genesis 2:18 (ESV) explains that after God created Adam, “The Lord God said, ‘It is not good that the man should be alone; I will make him a helper fit for him.’” Man was not created to live life isolated, but this also highlights the importance of those around us- choice or not.

Explanation of Addiction

The developmental model of addiction provides a strong rationale of addiction because it recognizes that one’s vulnerability is never static (Capuzzi & Stauffer, 2025). While this model seeks to understand when and how substance use becomes prevalent in specific populations, it also assesses other factors such as long-term health, well-being, resilience, and neurobiological pathways (Capuzzi & Stauffer, 2025). By assessing the complexity of biopsychosocial and organizational dynamics, this model identifies at-risk communities. This allows for meaningful interruption of unhealthy cycles and behaviors.

Conclusion

After assessing various models and approaches of explaining addiction, it is clear that many different causes and facilitators may exist. It is important for professionals to acknowledge the strengths of each model and then combine them to create a biopsychosocial approach to addiction. Addiction is extremely complex, as every client has their own unique experiences, beliefs, traumas, genetic predispositions, etc. By examining various aspects of addiction, professionals can best serve their client population on an individual basis.

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