Counselor, February 2001

Addiction Disease Concept:

Advocates and Critics

William L. White, M.A.

Editor's note: In the first two articles of this series, William L. White traced the evolution of the disease concept of addiction from the 18th century to the dawn of the 21st century. He noted its early rise and subsequent fall from prominence, its resurrection in the mid-20th century, and the subsequent growing debate in the late 20th century regarding its scientific credibility and personal and social usefulness. In this article, he explores the typical arguments between critics and advocates of the disease concept of addiction.

For more than 200 years, America has vacillated over the question of whether excessive drug use is a disease, an illness, a sickness, a malady, an affliction, a condition, a behavior, a problem, a habit, a vice, a sin, a crime, or some combination of these. A new century opens with debate over this question raging ever more intensely.

Both advocates and critics of the addiction disease concept (DC) include recovering people, physicians, psychiatrists, addiction counselors, addiction researchers, alcohol/drug policy experts, and leaders in the arenas of business, law, theology, and education. The fact that neither group speaks with one voice demands considerable care in our synthesis of the prevailing themes within the pro-disease and anti-disease camps. (Where intra-group disagreement exists, the competing positions will be numbered.)

Rational arguments about the DC can mask other issues that fuel the intensity of this debate: 1) personal survival and recovery, 2) professional rivalries over alcohol/drug-problem ownership, 3) financial interests (both personal and institutional), and 4) broader social and political agendas. This is a debate not just about ideas, but about the future of personal and professional lives as well as institutions and communities. The harsh collision of these interests helps account for exchanges that often generate more heat than light. Linda Mercadante has aptly described the risks taken when one enters the heart of this debate.

> *Today, the assertion that alcoholism is a disease is "sacred." It has achieved a level equivalent, in theological terms, to dogma: a fundamental, non-negotiable, undergirding belief. Alcoholism as disease is so foundational that one cannot deny it without distancing oneself from the believing community.*

There are other circles within which the rejection of the disease concept constitutes an equally dogmatic litmus test of credibility and inclusion. This is all a way of saying that we are about to enter hazardous territory.

Our focus in this article will, not be to take sides in this debate, but to synthesize as objectively as we can the propositions and counter-propositions that are at the center of this controversy.

Overview

DC Advocates: The addiction disease concept should be embraced for both its social and personal utilities. It conveys the seriousness of alcoholism/addiction to those suffering from it and to the public at large. It designates public health authorities as the agents responsible for the

prevention and treatment of the condition and encourages the development of local facilities for the treatment of addiction. The DC replaces moral censure and criminal punishment of the alcoholic/addict with unprejudiced access to health care institutions. It relieves guilt and increases help-seeking behavior. The DC provides an organizing construct through which the addicted client, his or her care providers, and those in the wider family and social environment can understand the nature of his or her problem (disease), the manifestations of that problem (symptoms), the potential causes of that problem (etiology), the natural evolution of that problem (course), interventions that are available to diminish or eliminate this problem (treatment options), and the likely outcome of such interventions (prognosis). The addiction disease concept is true and it works as an organizing construct for both the individual and society.

DC Critics: The addiction disease concept has survived only because of its historically brief social utility and the interconnected organizational empire that continue to profit from it. It should be abandoned because it is scientifically indefensible, fails to provide an adequate framework for prevention, strips the alcoholic/addict of freedom and responsibility, and is misapplied to types of alcohol/drug problems for which it is ill-suited. Labeling alcohol/drug problems as incurable diseases is stigmatizing and dissuades many heavy drinkers from seeking help. By restricting its definition of vulnerability for alcohol problems to a small group of alcoholic drinkers, the disease concept has allowed the alcohol/drug industries to escape culpability for their product and promotional practices.

The DC has led to the misdirection of public resources in the areas of research, prevention and the management of alcohol/drug problems. The addiction disease concept is not true, does not work and is harmful to individuals and communities.

Nature and Etiology of Alcohol/Drug Problems

DC Advocates: Alcoholism/addiction is a chronic primary disease suffered by the biologically susceptible drinker. It is a unitary entity and not symptom of any other disorder. Addicts are different from non-addicts. One either has or does not have the biological risk for addiction. According to one prominent DC advocate, alcoholism is a true medical disease rooted in abnormalities in brain chemistry bio-chemical aberrations that are inherited by the majority of alcoholics and, in some cases, acquired through intense and sustained exposure to alcohol and other drugs. Alcoholism and other addictions are comparable to such other chronic diseases as asthma, adult onset diabetes, and hypertensive disease.

DC Critics: 1. Sustained and excessive alcohol/drug consumption is not a physical disease but a symptom of an underlying emotional disorder or a failed attempt at self-cure of that disorder. 2. As unique clinical entities, alcoholism and addiction do not exist. These concepts are empty words used by well-intentioned but misguided people to medicalize socially deviant behavior. 3. Alcohol and other drug problems are a result of complex personal, interpersonal and environmental factors and are not the manifestation of a genetic disease. No such disease exists. What does exist is the *behavior* of excessive alcohol/drug use that can over time become a deeply ingrained *habit.* Alcoholics are not a distinct group, but exist on a continuum of drinking behavior and drinking consequences. All people who consume alcohol and other drugs are vulnerable for potential consequences related to such use, and these personal and social consequences are directly related to the frequency, intensity and duration of consumption. The focus should not be on the so-called *alcoholic* and this mythical disease *alcoholism*, but on how

to alter drinking/drugging behavior that is personally and socially harmful.

Course and Natural Outcome

DC Advocates: Alcoholism is a progressive disease that with continued drinking self-accelerates toward insanity or death. While sustained symptom remission is possible, it is not curable/reversible. The symptoms and stages of this disorder are extremely consistent in their character and sequence, varying only by gender and drug of choice. Such consistency allows for clear diagnosis and the delineation of early, middle and late stages of the disorder.

DC Critics: There is considerable variability in the onset, course and outcome of alcohol and other drug problems and even variability in the same individual over time. Alcohol and drug problems are inherently self-limiting. As frequency and intensity (volume) of consumption increases in tandem with aging, the probability of deceleration or cessation of use increases. This is confirmed in studies of controlled drinking, spontaneous remission, natural recovery or maturing out.

Most individuals who experience alcohol problems eventually shed such problems either by moderating their drinking or stopping their drinking without the aid of professional treatment or support group involvement.

Craving and Loss of Control

DC Advocates: Addiction disease is defined by the presence of two conditions: 1) a morbid, uncontrollable physical craving that fuels preoccupation and drug seeking behavior, and 2) a loss of control over alcohol/drug consumption. Loss of control can take two forms: the

inability to consistently refrain from alcohol/drug use and the inability to consistently control the quantity or duration of use once drinking or drug use has started.

DC Critics: The concepts of craving and loss of control lack scientific credence. Craving is little more than memory, and loss of control as something that happens every time the alcoholic starts drinking is scientifically untenable. Alcohol and other drug intake is under the volitional control of the user. Loss of control is a learned (acquired) behavior that can be consciously unlearned (discarded).

What is called loss of control is a cognitively mediated behavior produced by the belief the "one drink, one drunk" dictum that prevents alcoholics/addicts from developing moderated patterns of use.

Treatment

DC Advocates: Medical expertise is often needed to resolve alcohol/drug-related problems, and alcoholics and addicts deserve access to treatment on par with persons suffering from other medical disorders. The only legitimate goal of treatment is sustained abstinence from alcohol and other mood-altering drugs. (Nicotine and caffeine historically excluded here.)

The most effective model for treating alcoholism is the Minnesota Model of chemical dependency treatment. Treatment works: It is clinically effective and cost effective. The remission rates following addiction treatment are comparable to those for other chronic diseases. Treatment outcomes for those externally coerced into treatment are comparable to those who enter treatment voluntarily.

DC Critics: 1. Treatment is a failed social experiment that has turned into a multibillion-

dollar fraud. Most alcoholics recover not because of treatment but because they heal themselves. Public funds should not be used to support addiction treatment. 2. The most positively evaluated treatments (e.g., community reinforcement approach, cognitive-behavioral skills training, brief motivational interviewing) are not among the most frequently offered interventions for alcohol and other drug problems.

Mainstream approaches need to be expanded to include treatments that have greater scientific support. Abstinence as an exclusive treatment/recovery goal needs to be expanded to include the option of moderate drinking for some individuals. Coerced treatment is a violation of human rights and is not only ineffective but also harmful.

Mutual Aid Societies

DC Advocates: Life-long affiliation with Alcoholics Anonymous, Narcotics Anonymous or another 12-program is the most viable sobriety-based support structure for sustained addiction recovery. The best single predictor of long-term recovery can be found in the degree of sustained participation in AA/NA.

DC Critics: The majority of people who resolve alcohol/drug-related problems do so without affiliation with any mutual aid society. Enduring involvement in AA locks those with alcohol/drug problems into a closed social world inhabited only by others with such problems. It simply replaces one form of unhealthy dependence with another. Emphasizing the usefulness of recovering addicts as lay and professional helpers identifies alcoholics/addicts as persons worthy of emulation while ignoring those who act responsibly to avoid such problems. Twelve-Step groups are little more than religious cults; coercing someone to AA/NA or 12-step-oriented

treatment constitutes a violation of human rights and professional ethics.

Personal Culpability/Responsibility

DC Advocates: The alcoholic/addict is not responsible for his or her condition. People do not set out to willfully become addicted. The factors that separate the drinker who goes on to be an alcoholic and the non-problematic drinker are not factors over which the alcoholic has control.

Drinkers, and even heavy drinkers, drink by choice; alcoholics drink and get drunk in violation of their own intention not to and with full knowledge of the consequences and self-disgust that will follow.

Addiction is not a habit that can simply be consciously cast off, but a disease of the body and the will. Addiction is a no-fault disease. Once alcoholics/addicts are made aware of the nature of their condition and the steps that can be taken for its resolution, they become responsible for initiating and managing their own recovery.

DC Critics: The disease concept of addiction provides an excuse for past personally and socially destructive conduct as well as a rationale for continued drinking. Excessive drinking and/or drug use is not an addiction; it is a choice.

Alcoholics/addicts choose to become intoxicated, choose to continue to become intoxicated, and refuse to choose to be anything other than an addict. Such choice is driven not by disease but by weakness of character, "criminal self-indulgence," or "love of degrading vice."

The alcoholic/addict is responsible for when, where and how much they use as well as the consequences that accrue from such use. At worst, addiction is a habit under the control of the

will (as demonstrated by those who quit smoking) that can be broken like any other habit. The disease concept has taken freedom and responsibility from the individual and replaced it with professional power and governmental coercion.

Stigma

DC Advocates: The moral and social stigma attached to alcoholism/addiction contributes to the minimization and denial of alcohol/drug-related problems, prevents or postpones help-seeking behavior, and contributes to the social isolation of the alcoholic/addict and his or her family. Stigma closes doors of service by rendering the alcoholic/addict less qualified for healthcare services than someone who suffers from a "real" sickness, e.g., an innocent who cannot be held morally responsible for their problems. The disease concept has played a major role in reducing such stigma and opening the doors to treatment and recovery.

DC Critics: Stigma helps reduce alcohol problems and helps the alcoholic. Any effort to reduce the stigma of addiction will do a disservice to the alcoholic by reducing pressures to moderate consumption and could have the additional unintended effect of increasing the prevalence of addiction. What is needed is not less but more stigma attached to personally destructive and antisocial patterns of alcohol and other drug consumption.

Rhetorical Extremes and

Personal Animosities

The prior propositions and counter-propositions capture the views of the most prominent and perhaps fanatical disease concept advocates and critics. Such summaries provide only a

glimmer of the extremes to which the arguments and tempers on both sides of this debate have reached.

Training events that touch on this debate have deteriorated into intense acrimony between participants wedded to extreme pro- and anti-disease positions, disease critics have been personally accused of killing people with their ideas, and each new article and book seems more strident than those that came before. (A just-released book by Jeffrey Schaler declares: "The idea that addiction is a disease is the greatest medical hoax since the idea that masturbation would make you go blind.") In the face of such rhetorical excesses, one would be quite justified in expressing concern about the future of this debate and its implications for addicted individuals, families and communities, to say nothing of the field of addiction treatment,

It is this author's view that the disease concept that emerged in the mid-20th century was a beautiful concept for its time. It "worked" in the truest sense and it worked at personal, professional and cultural levels. However, this concept enters the 21st century with: 1) a poor scientific foundation; 2) a narrowly defined clinical profile that does not reflect the diversity of individuals seeking help for alcohol- and other drug-related problems; and 3) a poorly defined boundary that leaves it open to continued corruption and commercial exploitation.

The future of the disease concept will hinge on the ability of the addiction field to redefine this concept in light of accumulated scientific research and accumulated clinical and recovery experience.

Next: Is there a way out of this polarized disease debate? A proposal for a disease concept for the 21st century.

William L. White is a Senior Research Consultant at Chestnut Health Systems and the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. This article is abstracted from a work-in-progress entitled AA Disease Concept for the 21st Century.@

***Acknowledgment*:** Research for this article was supported by the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse.

Source Materials

Beauchamp, D. (1980). *Beyond alcoholism: Alcohol and public health policy*. Philadelphia: Temple University Press.

Blume, S.B. (1983). The disease concept of alcoholism. *Journal of Psychiatric Treatment and Evaluation* 5:471-478.

Cahalan, D. And Room, R. (1974). *Problem drinking among American men.* Brunswick: Rutgers Center of Alcohol Studies.

Chafez, M. (1966). Alcohol excess. *Annals of the York Academy of Sciences* 133:808-813.

Davies, J.B. (1992) *The Myth of addiction.* York: Harwood Academic Publishers.

Fingarette, H. (1989). *Heavy drinking: The myth of alcoholism as a disease.* Berkeley: University of California Press.

Gitlow, S. (1973). Alcoholism: A disease. In: Bourne, P.G. and Fox, R. Eds. *Alcoholism: Progress in research and treatment*. York: Academic Press.

Keller, M. (1976). The disease concept of alcoholism revisited. *Journal of Studies on Alcohol*

37(11):1694-1717.

Ketcham, K. and Asbury, W. with Schulstad, M. and Ciaramicoli, A. (2000). *Beyond the influence: Understanding and defeating alcoholism.* New York: Bantam Books.

Leshner, A.I. (1997) Addiction is a brain disease, and it matters. *Science* 278:45-47.

Lewis, D.C. (1993) A disease model of addiction. In: Miller, N. Ed., *Principles of addiction medicine.* Chevy Chase, MD: American Society on Addiction Medicine, pp. 1-7.

Menninger, K. (1938,1966). *Man against himself.* NY: Harcourt, Brace & World, Inc.

Mercadante, L. (1996). *Victims and sinners: Spiritual roots of addiction and recovery.* Louisville, KY: Westminster John Knox Press.

Milam, J. and Ketchum, K. (1983). *Under the Influence: A Guide to the Myths and Realities of Alcoholism*. New York: Bantam Books.

Peele, S. (1989). *The diseasing of America.* Lexington, MA: Lexington, Books.

Peele, S. and Brodsy, A. with Arnold, M. (1992). *The truth about addiction and recovery.* NY: Simon and Schuster.

Pomerleau, O., Pertschuk, M. and Stinnet, J. (1976). A Critical Examination of some current assumptions in the treatment of alcoholism. *Journal of Studies on Alcohol* 37(7):849-867.

Roman, P. (1988) Disease concept of alcoholism: Sociocultural and organizational bases of support. *Drugs and Society*, 2(3/4):5-31.

Schaler, J. (2000) *Addiction is a choice*. Chicago: Open Court.

Szasz, T. (1972). Bad habits are not diseases: A refutation of the claim that alcoholism is a disease. *The Lancet*, (July 8) 2:83- 84.

Szasz, T. (1974). *Ceremonial chemistry*. Garden City, NY: Anchor Press.

Trimpey, J. (1996). *Rational Recovery: The new cure for substance addiction*. New York: Pocket Books.

Vailant, G. (1983). *The natural history of alcoholism: Causes, patterns, and paths to recovery*. Cambridge, MA: Harvard University Press.

Vaillant, G. (1990). We should retain the disease concept of alcoholism. *The Harvard Medical School Mental Health Newsletter* 6(9): 4-6.

Wallace, J. (1989) *Writings: The alcoholism papers*. Newport, RI: Edgehill Publications.