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Addiction as a Disease: The Birth of a Concept

William L. White

First in a series on the history and future of the disease concept of addiction.

Are alcoholism and other addictions diseases? If so, what manner of diseases are they, and how can they best be treated? If not, then how else do we understand and respond to such conditions? Do we need more than one organizing concept to embrace the myriad patterns of harmful alcohol and other drug (AOD) use? What personal, professional and social consequences flow out of these different frameworks for viewing AOD-related problems?

Such questions have been the subject of heated debate in America for more than 200 years. The heightened crescendo of this debate leaves open the question of how this country and her citizens, and how we as addiction counselors, will understand and respond to AOD problems in the 21st century.

Ideas and Language: What is at stake here?

The ideas and words we use to frame AOD problems matter, and they matter at many levels.

At a personal level, such concepts can serve a preventative function, facilitate early self-recognition and self-correction of AOD problems, or provide a metaphor for transformative change for those in serious trouble in this person-drug relationship. When ill-chosen, these concepts can fail to perform these important functions.

At a community level, these concepts declare what people and institutions we want to have cultural ownership of AOD problems. Whether such ownership is in the hands of a priest, a police officer, a physician, a psychiatrist, a social worker, or a political activist affects the community as a whole, the fate of individual organizations and whole fields of professional endeavor, as well as innumerable careers. The debate over the disease concept and its alternatives cannot be easily separated from these broader interests.

For those who have been given ownership of AOD problems, these concepts, at their best, offer precision in problem diagnosis and the selection of effective interventions. The nature of interventions into people's lives, for good or

for bad, flows directly from these conceptual foundations.

The concepts we use to portray AOD problems also serve larger cultural, social, and economic agendas as they are differentially applied to people of different ages, races, genders, social classes and sexual orientations. It is only in viewing such contextual influences that we can understand how one drug-involved person is viewed as suffering from a disease and offered health care resources while another drug-involved person is viewed as a criminal and is incarcerated.

The debate over the disease concept of addiction is not a meaningless intellectual exercise. Any framework for understanding AOD problems will exert a profound influence on the lives of individuals, families, social institutions, and communities. The fact that these concepts must “work” at so many levels and the seeming intractability of AOD problems in the history of America have contributed to the conceptual instability of the AOD problem arena. No addiction model has ever fully replaced its competitors; radically different conceptualizations of AOD problems have always co-existed, and our citizenry has always been ambivalent about whichever model claimed temporary prominence.

Our task for the coming months will be to explore (in this continuing series of articles) the history and future of one such framework: the disease concept of addiction.

The Birth of the Disease Concept of Addiction

The conceptualization of chronic drunkenness as a disease did not originate in America. References to chronic drunkenness as a sickness of the body and soul and the presence of specialized roles to care for people suffering from “drink madness” can be found in the ancient civilizations of Greece and Egypt. Isolated and periodic references to chronic drunkenness as a disease, and even occasional calls for state-sponsored treatment, continued through the centuries before the first European migrations to America.

It took a lot to birth a disease concept of alcoholism in America. A breakdown of community norms that had long contained drunkenness in colonial America and a shift in consumption patterns from fermented beverages to distilled spirits led to a dramatic (nearly three-fold) increase in alcohol consumption between 1790 and 1830. In face of these changes, several prominent individuals “discovered” addiction and called for a new way of understanding and responding to the chronic drunkard.

Anthony Benezet In 1774, the philanthropist and social reformer Anthony

Benezet expressed his alarm at changing drinking practices in colonial America . In the first American treatise written on alcoholism, Benezet challenged the prevailing view of alcohol as a gift from God. He christened alcohol a “bewitching poison,” described “unhappy dram-drinkers bound in slavery,” and noted the tendency for drunkenness to self-accelerate (“Drops beget drams, and drams beget more drams, till they become to be without weight or measure.”).

Benjamin Rush Benezet’s warning was followed in 1784 by Dr. Benjamin Rush’s *Inquiry into the Effects of Ardent Spirits on the Human Mind and Body*. Rush achieved five things with this highly influential pamphlet. 1) He medically catalogued the signs of acute and chronic drunkenness. 2) He introduced a more medicalized language into the discussion of intemperance by describing “persons addicted to ardent spirits” and by declaring that chronic drunkenness was an “odious disease” and a “disease induced by a vice.” 3) He medically confirmed Benezet’s observation about the progressiveness of intemperance by noting that such episodes “gradually increase in their frequency.” 4) He offered medical speculation about the causes of this disease. 5) He provided the first recommended treatments for chronic drunkenness based on a disease concept of addiction. Rush later used this embryonic disease concept to call for the creation of a special facility (a “Sober House”) to care for the drunkard.

Lyman Beecher In the Reverend Lyman Beecher’s *Six Sermons on the Nature, Occasions, Signs, Evils, and Remedy of Intemperance* delivered in 1825, we find a growing bridge between moral and medical views of drunkenness. Beecher declared that the intemperate are “addicted to the sin,” referred to intemperance as an “evil habit” fueled by “an insatiable desire to drink,” observed that intemperance can “hasten on to ruin with accelerated movement,” and, then detailed the exact warning signs of this addiction to drink. Beecher concluded his sermons by declaring: “Intemperance is a disease as well as a crime, and were any other disease, as contagious, of as marked symptoms, and as mortal, to pervade the land, it would create universal consternation.” Where Benezet and Rush had described the consequences of chronic drunkenness, Beecher described the process of becoming a drunkard and he did so by offering his listeners and readers a remarkably modern checklist of the warning signs that mark the loss of volitional control over alcohol consumption.

Samuel Woodward In the 1830s, the prominent physician Samuel Woodward, recommended the creation of special asylums for the treatment of the inebriate. Woodward described how intemperance was a “physical disease which preys upon his (the drunkard’s) health and spirits... making him a willing slave to his appetite.” Woodward aptly described the paradoxical entrapment of the

drunkard whose source of woe and source of greatest comfort were both to be found in alcohol. He spoke of the role of heredity as a causative factor in chronic drunkenness, evoked powerful images of “the never-dying worm of intemperance...preying upon his [the drunkard’s] vitals,” and described the way in which the quantity of alcohol consumed by the intemperate must be ever increased to sustain its effect. Woodward believed that the drunkard should be taught the nature of his disease.

Show to him...the reason why the case is not controllable by the will, that it is a physical evil, a disease of the stomach and nervous system, and entirely incurable while the practice is followed...

William Sweetser Dr. William Sweetser reflected a very modern understanding of disease and the complexities of viewing chronic drunkenness in this framework when he argued in 1829 that intemperance directly and indirectly created a “morbid alteration” in nearly all the major structures and functions of the human body. He believed many individuals “addicted to intemperance” were vulnerable to such alterations as a result of heredity or accidental circumstance. Sweetser viewed cycles of compulsive drinking for such individuals as the product of a devastating paradox: the poison--alcohol, was, itself, its only antidote. Sweetser had great difficulty reconciling his emerging medical understanding of addictive disease with American ideas of free will and personal responsibility. His worries reflect tensions that will continue for nearly two centuries.

Now that it (intemperance) becomes a disease no one doubts, but then it is a disease produced and maintained by voluntary acts, which is a very different thing from a disease with which providence inflicts us....I feel convinced that should the opinion ever prevail that intemperance is a disease like fever, mania, &c., and no moral turpitude be affixed to it, drunkenness, if possible, will spread itself even to a more alarming extent than at present.

Roots of Addiction Medicine We can see in these late 18th and early 19th century writings of Benezet, Rush, Woodward and Sweetser a cluster of ideas that will become the building blocks of an emerging disease concept of alcoholism: biological predisposition, drug toxicity, morbid appetite (craving), pharmacological tolerance, disease progression, inability to refrain from drinking, loss of volitional control over quantity of alcohol intake, and a detailed accounting of the biological, psychological, and social consequences of chronic drunkenness.

We also see in these early writing the struggle to distinguish drunkenness as a vice from drunkenness caused by disease. Early disease concept advocates did not view intoxication itself as a disease, but as a potential symptom of disease. The disease itself was portrayed as: 1) the cluster of physical and social problems produced by chronic drunkenness, and 2) the “ungovernable appetite” that overwhelms willful choice and control of alcohol intake. We also see (in everyone following Rush) a clear opinion that the only hope for the diseased drunkard is complete and enduring abstinence from all forms of alcohol and other drugs—as Woodward would advise: “nothing stimulating, both now and forever.”

These early writings stand out not because they represented the dominant view of their day, but because the then controversial ideas of these men marked the beginning of an experiment in conceptualizing drunkenness and the drunkard in a fundamentally new way. The gadfly call for a medicalized view of intemperance in the late 18th and early 19th centuries was bolstered by rapidly expanding knowledge about the physical effects of excessive alcohol consumption. This new knowledge, which ranged from the first studies of delirium tremens to the discovery of the toxic effects of alcohol on the stomach, blood, and nervous system, reached a pinnacle in 1849 in the work of the Swedish physician Magnus Huss. Huss’s landmark study bolstered this emerging disease concept and gave the condition a new name: alcoholism. After detailing the multiple organ systems effected by chronic alcohol exposure, Huss noted:

These symptoms are formed in such a particular way that they form a disease group in themselves and thus merit being designated and described as a definite disease...It is this group of symptoms which I wish to designate by the name Alcoholismus chronicus.

The works of Rush, Woodward, Sweetser and Huss called attention to chronic drunkenness as a problem that physicians should study and treat. As physicians took up this challenge, the terms “drunkenness” and “intemperance” gave way to a more medicalized language that designated this newly formulated disease and the sufferer: *inebriety/inebriate*, *dipsomania/dipsomaniac*, and *alcoholism/alcoholic*. It was during this time that the term “disease” (of alcoholism) was used to designate a real thing that was believed to have a power and life of its own.

Next: the application of the disease concept to drugs other than alcohol and the role of the disease concept in America’s first mutual aid societies and treatment

institutions.

William L. White is 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 "A Disease Concept for the 21st Century."

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The Addiction-Disease Concept: Its Rise and Fall in the 19th Century

William L. White

Second in a series on the history and future of the disease concept of addiction.

In the last article, we explored the way in which new “disease” conceptions of addiction emerged and co-existed alongside the more popular perceptions of chronic intemperance as a product of sin, vice, indulgence, and habit. We noted how the speeches and publications of prominent social reformers, clergy, and physicians had birthed a disease concept of addiction, defined core elements of this concept, and catalogued the wide-ranging consequences of what Magnus Huss, in 1849, christened *chronic alcoholism*.

In this article we will describe the limited role the disease concept played in 19th century alcoholic mutual aid societies, the application of this concept to drugs other than alcohol, and the major role the disease concept played in 19th century addiction treatment. We will also hear from some of the earliest critics of the disease concept.

19th Century Mutual Aid Societies

There were many formally organized alcoholic mutual aid societies in the 19th century: The Washingtonians, the fraternal temperance societies, the reform clubs and such institutional aftercare associations as the Ollapod Club and the Godwin Association. None of these groups made the disease concept a centerpiece of their movements, but nearly all tended to see the roots of inebriety more in medical terms than in moral terms. From the Washingtonian literature of the 1840s we read, “He (the drunkard) knows and feels that drunkenness with him is rather a *disease* than a *vice*,” and we find a large gathering of Keeley League members sitting under a banner in 1892 that reads, “The Law Must Recognize a Leading Fact, Medical not Penal Treatment Reforms the Drunkard.” But it should be emphasized that the disease concept was a peripheral concept for America’s earliest alcoholic mutual aid societies.

What the 19th century alcoholic mutual aid societies did emphasize was the power of public commitment to total abstinence, alcoholic-to-alcoholic “experience

sharing,” sober fellowship, and service to other alcoholics. Little time was spent in these societies pondering how one became an alcoholic and none used the concept of “disease” as an organizing metaphor for personal sobriety.

“The Opium Disease”

As a medicalized concept of addiction rose on the American cultural landscape, a unique class of drugs sought the embrace of this concept. Epidemics of infectious disease and a spectrum of other painful medical disorders rendered 19th century Americans of all ages in need of and vulnerable to the effects of narcotic drugs. The oft-times indiscriminate dissemination of opiate-laced medicines by physicians, the pervasive presence of a predatory patent medicine industry, and such technical developments as the isolation of morphine from opium and the introduction of a perfected hypodermic syringe all contributed to a rise in narcotic addiction. Whatever suffering medicine could not cure in the 19th century, morphine and the hypodermic syringe could alleviate.

The cultural perception of opiate addiction evolved over the 19th century from that of a misfortune, to that of a vice, to proposals that such dependence should be viewed as a disease. The latter view emerged in tandem with the growing awareness of the addictive properties of opium. By the 1850s, the power of opium over human will was increasingly illustrated by such aphorisms as: “It is not the man who eats Opium, but it is Opium that eats the man.”

While the dominant profile of the 19th century opiate addict was a white, middle-aged woman, opiate use was publicly linked to Chinese immigrants at a time (the 1870s) of heightened racial and class conflict surrounding the question of Asian immigration. The creation of America’s first “dope fiend” caricature slowed the perception of opiate addiction as a medical disorder and injected the issue of racism into the public perception of opiate use. This was true even where the disease concept prevailed. Eating and injecting opiates—the pattern most prevalent among affluent whites—was referred to as a disease, while the smoking of opium—a pattern associated with the Chinese—was consistently labeled a vice.

In the face of America’s first anti-“drug” (opium) campaign, attacks on the disease concept of narcotic addiction increased, even from physicians. One of the most outspoken critics of the disease concept of opiate addiction was Dr. C.W. Earle of Chicago.

It is becoming altogether too customary in these days to speak of vice as disease...That the responsibility of taking the opium or whiskey...is to be

excused and called a disease, I am not willing for one moment to admit, and I propose to fight this pernicious doctrine as long as is necessary.

By the 1880s, addiction specialists were using terms such as “the drug vice” and “dreadful habit” to describe opiate addiction at the same time they described patients who “continued until the drug produced its *own disease*.” This mixture of moral and medical language was common in the addiction literature of the 19th century. The conceptualization of “morphinism” as “a disease of the body and mind,” while still poorly developed and quite controversial, began to slowly move into the mainstream medical literature. Simultaneously, addiction to alcohol and other drugs were embraced within a new term, *inebriety*, that captured a wide variety of drug choices, patterns of use, and types of resulting problems.

The Disease Concept of Inebriety

During the second half of the 19th century, a multi-branched profession emerged that specialized in treatment of alcohol, opium, morphine, cocaine, chloral, and ether inebriety. The story of specialized treatment institutions based on a disease concept of inebriety begins with the opening of the New York State Inebriate Asylum in 1864, whose founder, Dr. Joseph Turner, had long advocated such a concept. In 1870, the superintendents of several inebriate asylums and homes established the American Association for the Cure of Inebriety (AACI). The first four founding principles of the AACI were the following.

- 1. Intemperance is a disease.*
- 2. It is curable in the same sense that other disease are.*
- 3. Its primary cause is a constitutional susceptibility to the alcoholic impression.*
- 4. This constitutional tendency may be either inherited or acquired.*

The AACI's *Journal of Inebriety* published hundreds of disease-themed papers that were joined by a growing number of medical texts on inebriety that advocated a disease concept of addiction. The flavor of these writings can be illustrated from the work of two of the most prominent leaders of the AACI.

Dr. Joseph Parrish, the founding spirit of the AACI, summarized his views on inebriety in 1888. He began by distinguishing between drunkenness as a vice and drunkenness as a disease, noting that the latter was fueled not by weakness of moral character but by a pathological and nearly irresistible appetite for alcohol.

It is the internal craving for alcoholic liquors, and for their intoxicating effect, that constitutes the disease, and not the fact of drunkenness.

Parrish, like many 19th century inebriety specialists, didn't so much reject the view of drunkenness as vice as suggest that a line could be crossed where drunkenness evolves into a disease that is no longer under the conscious control of the drinker. He believed that there were multiple sources for this disease process but that the most significant of such sources were of biological origin. According to Parrish, heredity provided a "moral and physical predestination" that made a drunkard of one while protecting his neighbor from a similar fate.

Like Parrish, Dr. T.D. Crothers believed that the disease of inebriety had multiple causes (e.g., heredity, illness, emotional excitement, adversity), presented itself in quite varying patterns (e.g., chronic, intermittent), and required highly individualized treatments. What Crothers considered the "disease" was the "constitutional proclivity, or neurosis" which fueled excessive alcohol and other drug use. Crothers believed that such proclivity often had a physical source and manifested itself in a morbid appetite that ignited the manic pursuit of intoxication. Crothers had a special interest in how this concept could be reconciled with questions of human will and responsibility.

The disease concept of inebriety was the centerpiece of the work of Parrish, Crothers, and other leaders of the medical wing of the AACI. They saw this concept as the foundation of the movement to treat inebriety medically and scientifically and to garner support for specialized institutions where inebriates could be treated.

The proprietary addiction cure institutes of the 19th century also used the disease concept to buttress their marketing efforts. Franchised chains of addiction cure institutes, often bearing the names of their founders—Keeley, Gatlin, Neal, Oppenheimer—advertised that inebriety was a disease that could be cured with the purchase of their injections or bottled cures. Later exposés related to the presence of alcohol, opiates and cocaine in such products helped undermine the credibility of the disease concept that was used to promote these alleged cures.

19th Century Disease Concept Critics

Support for a "disease concept" was by no means unanimous among those who cared for the inebriate. The most fully articulated opposition to the disease concept among the inebriate institutions came from the leaders of the Franklin

Reformatory for Inebriates in Philadelphia. Dr. Robert Harris expressed the philosophy of this institution as early as 1874, when he declared the following:

As we do not, either in name or management, recognize drunkenness as the effect of a diseased impulse; but regard it as a habit, sin, and crime, we do not speak of cases being cured in a hospital, but “reformed.”

Leaders of the Franklin Reformatory attacked the disease theory as “a weak apology for the sin of drunkenness” and a “blasphemy against God.” At the same time, they portrayed the inebriate as the victim of a society that through its promotion of drinking seduced the innocent into an unbreakable habit. We see in these views the struggle to reconcile the idea of free will with metaphors of slavery and entrapment that mark the growing emergence of the concept of addiction—a concept that was calling into question the limits of human will.

Some of the strongest attacks on the disease concept were rooted in an alternative view of chronic drunkenness proposed by evangelical Christians. This view, which found its practical application in religious revivals, the urban mission movement, and religiously sponsored inebriate colonies, viewed drunkenness as a sin against God that could only be cured by religious conversion. The tension surrounding the disease concept of inebriety reflected the different ways science and religion were defining the source and solution to the problem of intemperance.

Many of those concerned about alcohol and other drug problems in the 19th century had difficulty defining the exact nature of these problems. Phrases like “addicted to sin,” “moral disease,” and “disease induced by a vice,” and the interchangeable use of such terms as “habit,” “indulgence,” and “disease” represent the enduring confusion and ambivalence about the precise character of such problems. Many tried to reconcile these seemingly conflicting views by arguing that there existed a continuum of human will in which one could choose to begin drinking, choose to continue to drink, but at some point lose the power to not drink.

The Fate of the First Disease Concept

The disease concept of the 19th century competed against three alternative views of alcohol and other drug problems. One view, which we have highlighted, concurred that the source of the problem was in the person but defined the problem in terms of vice and sin. The second view portrayed the source of the problem not in the person but in the product (alcohol, particularly distilled spirits, opium, and

cocaine). A third view contended that America's drug problems were being caused by the aggressiveness with which alcohol and other drug use were being promoted by new distilleries and breweries, a new corruption-plagued institution (the saloon), and by physicians and pharmacists. Quite different proposals to solve America's alcohol and other drug problems emerged from each of these views. These contrasting views co-existed throughout the 19th century with each vying for prominence.

The disease concept as a purely medical concept fell out of favor at the end of the 19th century in tandem with the fall of the treatment institutions in which it had been imbedded. The demedicalization of addiction rose in the wake of alcohol and drug prohibitions movements that took their turn trying to resolve America's alcohol and other drug problems. Temporarily swept away was the language of "disease" and many elements of this embryonic concept: biological vulnerability (propensity), tissue tolerance, morbid appetite (craving), progression, obsession, and behavioral compulsion. We shall see in future articles how the core elements of the 19th century's disease concept of addiction will come to be rediscovered and how they will again stir new debates regarding their scientific validity and their moral consequences.

William L. White is the author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*.

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The Rebirth of the Disease Concept of Alcoholism in the 20th Century *William L. White*

Third in a series on the history and future of the disease concept of addiction.

The first article of this series described the rise of a disease concept of intemperance in the late 18th century, the extension of this concept to opiate and cocaine addiction, the prominent role of the disease concept in 19th century inebriate asylums and homes, and the diminishing popularity of the disease concept as the 20th century opened. This article will trace the addiction-disease concept through the 20th century, depicting its hibernation, re-emergence, and commercialization.

1900-1942: Dormancy

America's first addiction-disease concept was swept away in the transition between the 19th and 20th centuries. While individual physicians continued to advocate various disease concepts of addiction, the overall definition of alcohol and drug problems shifted from a focus on a vulnerable minority of users to a focus on the inherent "badness" of the drugs and the persons and institutions profiting from their sale. Cultural pessimism about the potential for permanent recovery, combined with exposés of fraudulent cures, contributed to a dramatic decline in addiction treatment and the rise of laws banning the non-medical use of alcohol, narcotics, and cocaine. Alcoholics and addicts, once "patients" worthy of sympathy, became "common drunkards" and "dope fiends" portrayed, at worst, as moral weaklings and criminals, and, at best, as dangerously insane.

This transition in attitude reflected and continued to fuel changes in state and federal laws. The Harrison Act of 1914 brought narcotics and cocaine under federal control by designating physicians as the gatekeepers for the legitimate distribution of these drugs. Subsequent Supreme Court decisions and law enforcement policies inadvertently shifted responsibility for the care of addicts from physicians to criminal syndicates. The voices of physicians who protested this change on the grounds that addiction was a treatable disease were silenced amid the larger cultural redefinition of the addict from that of a sick person worthy of sympathy and support to that of a psychopath deserving isolation and

punishment.

Even when disease metaphors were used in the early 20th century, they were expressed in language that emphasized the danger the addict posed to the community. Winifred Black in her 1928 best seller, *Dope: The Story of the Living Dead*, depicted drug addiction as a “a wasting, loathsome, hideous, cruel disease” and portrayed the addict as a “carrier” of a disease “worse than smallpox, and more terrible than leprosy.” The sequestration that Black and others called for was not in medically-directed specialty institutions but in federal penitentiaries.

The advent of Prohibition in 1919 similarly altered the country’s perception of and response to the alcoholic. By the early 1920s, the bold 19th century proclamation that alcoholism was a disease had become a dying whisper that faded with the treatment institutions it had spawned. As the addiction disease concept fell from popularity and as specialty institutions closed, the care of alcoholics and addicts shifted to penal institutions (inebriate colonies and “drunk tanks”) to the “foul wards” of large public hospitals and to the fledgling field of psychiatry. Most psychiatrists of this era framed excessive alcohol and other drug use not as a primary disease, but as a superficial symptom of underlying psychological disturbance. The important intervention, according to this theory, was treatment of the hidden, unconscious forces that drove excessive drug use.

Psychiatry’s reluctant assumption of responsibility for the problems of alcoholism and narcotic addiction had two notable outcomes. First, it formed the theoretical foundation for what were quite humane efforts to find effective treatments. These included the Emmanuel Clinic model and its use of recovered alcoholics as lay therapists, the treatment of affluent alcoholics and addicts in private hospitals and sanatoria, and eventually new outpatient alcoholism clinic models in Connecticut and Georgia.

More ominously, this view subjected alcoholics and addicts to whatever psychiatric treatments were in vogue and to prevailing social policies toward the mentally ill. Thus, alcoholics and addicts were swept under the umbrella of mandatory sterilization and legal commitment laws in the early 20th century, and were subjected to often lethal withdrawal regimes, psychosurgery (prefrontal lobotomies), chemical and electroconvulsive therapies, and drug therapies that eventually included barbiturates, amphetamines, and LSD. Alcoholics and addicts, where they could be admitted, were subjected to the worst abuses of mental health institutions.

The importance of the early 20th century to our story is what it reveals about

the consequences of abandoning a disease concept of addiction in the absence of an alternative concept that “works” at personal, professional, and cultural levels.

AA and the Disease Concept: A Complex Connection

It is difficult to pick up a book advocating or attacking the disease concept of alcoholism/addiction without having Alcoholics Anonymous credited as the source of the modern disease concept of alcoholism. Yet considerable evidence challenges this popular belief. When AA co-founder Bill Wilson was asked in 1960 about AA’s position on the disease concept, he offered the following response:

“We have never called alcoholism a disease because, technically speaking, it is not a disease entity. For example, there is no such thing as heart disease. Instead there are many separate heart ailments, or combinations of them. It is something like that with alcoholism. Therefore, we did not wish to get in wrong with the medical profession by pronouncing alcoholism a disease entity. Therefore, we always called it an illness, or a malady – a far safer term for us to use.”

AA’s use of medical terms reflects not an observation on the source or nature of alcoholism but its belief about the solution. When Wilson asked Dr. Bob Smith, AA’s other co-founder, to comment on the accuracy of referring to alcoholism as disease or one of its synonyms, Smith scribbled in a large hand on a small sheet of his letterhead: “Have to use disease – sick – only way to get across hopelessness.” AA’s use of medical metaphors served as a reminder of its belief that the alcoholic could never again safely drink alcohol.

In a paper that looks specifically at whether AA was the source of the disease concept, historian Ernest Kurtz, author of *Not God: A History of Alcoholics Anonymous*, summarizes his review of AA literature and practices:

“On the basic question, the data are clear: Contrary to common opinion, Alcoholics Anonymous neither originated nor promulgated what has come to be called the disease concept of alcoholism. In the major texts of AA, there appear no discussions and bare mention of “disease,” much less of the disease concept of alcoholism. Its paucity of mention in the officially published works suggests that this understanding is hardly

central to the thought of Alcoholics Anonymous. Yet its members did have a large role in spreading and popularizing that understanding. Most AA members, in the year 2000 no less than in 1939, will tell an inquirer that their alcoholism has physical, mental, emotional, and spiritual dimensions. The contribution of Alcoholics Anonymous is not the idea of *disease* but of *threefold* disease – the realization that the alcoholic had problems in the physical, the mental, and the spiritual realms, the clear understanding that alcoholism is, as described on page 44 of *Alcoholics Anonymous*, ‘an illness which only a spiritual experience will conquer.’ Did AA’s use the disease concept of alcoholism? Yes. Did AA’s or AA originate or rediscover or dogmatically push the disease concept of alcoholism? Clearly, No.”

What AA did contribute inadvertently to the disease concept – its goal was not to understand alcoholism but to help alcoholics – was its members’ collective experience. This experience reflected:

- the reality that alcoholism had a physical, as well as a mental and a spiritual, component
- the potential helpfulness of medical metaphors (“illness,” “allergy”) in making sense of drinking experiences
- the portrayal of alcoholism as an accelerating process
- the importance of concentrating on drinking behavior rather than searching for underlying causes
- a belief that loss of control over alcohol could be contained only by complete abstinence from alcohol.

AA was not the source or promoter of the disease concept that emerged in the 1940s as a public policy slogan and an organizing construct for alcoholism treatment. AA’s peripheral use of such medical metaphors was not a declaration of science but a simple statement of collective experience. (“It explains many things for which we cannot otherwise account.” *Alcoholics Anonymous*, xxiv)

1942-1970: Modern Movement

The source of a rediscovered addiction disease concept in the mid-20th century begins with three organizations: the Research Council on Problems of Alcohol (founded in 1937), the Yale Center of Alcohol Studies (1943), and the National Committee for Education on Alcoholism (1944). RCPA, Yale, and

NCEA collectively provided the driving force behind the “modern alcoholism movement” – a term intended to convey a focus on alcoholism, rather than on alcohol or the broad spectrum of alcohol-related problems. This movement met the cultural need to escape a century of polarized wet-dry debates and provided these organizations with hope for institutional funding of their research and educational agendas. The newly defined problem was the unique vulnerability of a small subpopulation of drinkers.

In 1942, Dwight Anderson of the RCPA published a seminal article in the *Quarterly Journal of Studies on Alcohol* in which he advocated a sustained public education campaign to reframe alcohol problems in terms of sickness rather than vice. Anderson proposed four “kinetic ideas” as the centerpiece of this campaign.

- The problem drinker is a sick man, exceptionally reactive to alcohol.
- He can be helped.
- He is worth helping.
- The problem is therefore a responsibility of the healing professions as well as health authorities and the public.

When Marty Mann founded NCEA in 1944, she integrated Anderson’s ideas into her own proposed campaign, but she incorporated the words “alcoholism” and “alcoholic” into Anderson’s kinetic ideas and added a fifth element, which she listed first:

- Alcoholism is a disease.

Mann spent the rest of her life leading the campaign to change America’s conception of alcoholism and the alcoholic and to create local resources for alcoholism treatment and recovery.

The model of alcoholism treatment that most exemplified the disease concept subsequently emerged from the synergy of three programs in Minnesota: Pioneer House (1948), Hazelden (1949), and Willmar State Hospital (1950). This model drew heavily on the experience of AA members in its conceptualization of alcoholism as a primary, progressive disorder whose management required sustained abstinence and an active, continuing program of recovery.

The story of the disease concept and the modern alcoholism movement would be incomplete without noting the influential work of E.M. Jellinek at the RCPA and Yale. Jellinek’s *Disease Concept of Alcoholism* (1960) stands as the most widely cited (and least read) literary artifact of the modern alcoholism movement. In it, Jellinek noted the growing acceptance of the disease concept of alcoholism but expressed his reservations about this oversimplified

understanding of the disorder.

He suggested that there were a variety of “alcoholisms,” only two “species” of which he thought merited the designation of disease, and went on to criticize the tendency to characterize alcoholism as a single disorder. Jellinek’s concern reflected that of other scientists who, even as the disease concept was being culturally embraced, feared a future day of reckoning for this simplistic portrayal of alcoholism. Among these scientists was Dr. Harry Tiebout, AA’s first friend in the field of psychiatry and a leading supporter of the modern alcoholism movement, who as early as 1955 raised such fears:

“[T]he idea that alcoholism as a disease was reached empirically by pure inference. It had never been really proved. ... I cannot help but feel that the whole field of alcoholism is way out on a limb which any minute will crack and drop us all in a frightful mess. To change the metaphor, we have stuck our necks out and not one of us knows if he will be stepped on individually or collectively. I sometimes tremble to think of how little we have to back up our claims. We’re all skating on pretty thin ice.”

Two new mid-century addiction treatment modalities influenced thinking about the application of the disease concept to drugs other than alcohol. First, the therapeutic community emerged as a treatment modality for drug addiction. Most early TCs rejected the disease concept, isolated themselves from AA and Narcotics Anonymous, and instead based their treatment on the process of character reconstruction.

Second, methadone maintenance became the major approach to the treatment of narcotic addiction. MM pioneers in both their theoretical orientations and their clinical procedures viewed opiate addiction as a metabolic disease.

1970-2000: Concept Extension and Backlash

By 1980, it appeared that many of the goals of the modern alcoholism movement were being achieved. The movement had extended its influence into major cultural institutions (media, law, medicine, religion, education, business and labor). There was growing professional and public acceptance of the proposition that alcoholism was a disease. The country had established national institutes that advocated medical research on addiction and public health approaches to alcohol and other-drug related problems. People from all walks of

life, including First Lady Betty Ford, were publicly declaring their recovery from alcoholism. The disease concept was being applied to a wide spectrum of other drugs and behaviors as recovery briefly became something of a cultural phenomenon. There was an explosive growth of treatment programs – particularly hospital-based and private programs – that used the disease concept.

The most widely replicated treatment approach in both private and public programs was the Minnesota Model, which perceived addiction as a primary disease. In short, the disease concept altered the public's conception of the alcoholic and challenged medical and public health authorities to take responsibility for the treatment of alcoholism – a significant achievement.

Every significant social movement has the potential to generate a counter-movement, and this happened with alcoholism movement. The backlash came in two forms. The first was a financial backlash against the business-practice excesses of the treatment industry. Aggressive programs of managed care that restricted treatment access and duration led to a plummeting daily census within, and the eventual closing of, many inpatient programs. Particularly impacted was the prototype 28-day inpatient treatment program that had most exemplified the disease concept. The second backlash was ideological and took the form of growing philosophical and scientific attacks on the disease concept and the treatment programs based on it.

The 20th century ended without popular or professional consensus on the nature of alcohol and other drug problems and the strategies that could best resolve these problems at a personal or cultural level. Scientific breakthroughs in genetics and neurobiology that promised to bolster the disease concept were offset by scientific findings that challenged some of the basic tenets of this concept. Such conceptual confusion left critics and advocates alike speculating about the fate of the addiction disease concept in the 21st century.

Next: Disease concept components, critics and criticisms.

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Addiction Disease Concept: Advocates and Critics

William L. White, M.A.

Editor's note: In the first 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 Animosity

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.

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A Disease Concept for the 21st Century

William L. White

In the first three articles in this series, we reviewed the history of the disease concept of addiction in America from its birth in the 18th century through its collapse, rebirth and rising prominence in the 20th century. We also noted the emergence and growing stridency of an addiction disease debate and isolated the major points of contention between addiction disease advocates and critics. In this final article, I will cast aside the role of historian and offer my own conclusions and proposals regarding this concept and its future.

Toward a Better Disease Model

When Alcoholics Anonymous was first publicly criticized in a 1963 magazine article, A.A. cofounder Bill Wilson responded in the *A.A. Grapevine*. Rather than attacking the author or defending A.A., Wilson took the position that A.A. members should view critics as benefactors and that A.A. should use criticism lodged against it to self-assess and improve A.A. Those of us who have long-professed that addiction is a disease would be well-served by Wilson's example. Rather than defending an overly rigid concept, it would be better to acknowledge the weaknesses of the disease concept as historically constructed and to reformulate a disease concept that is more clinically and culturally dynamic and more scientifically defensible. Improving the addiction disease concept stands as a viable alternative to the critics' strident call for its abandonment.

William Miller warned in 1993 that the current disease model was inadequate to explain or resolve the wide spectrum of alcohol-related problems. This article builds on his proposal to construct a modernized disease concept within the rubric of a public health approach to disease prevention and intervention--an approach that provides a balanced focus on the agent (the drug), the vulnerability of the host (the drug consumer) and the (physical/cultural/legal) environment.

The Tower of Babel.

The new disease concept will forge consensus on a language that can be used to differentiate types and intensities of alcohol- and other drug-related problems. Any conceptualization of such problems must contain a core set of words and ideas that can simultaneously: 1) help individuals construct or change their relationship with psychoactive drugs, 2) guide professional helpers in organizing and evaluating their interventions into drug-related problems, and 3) help communities and societies understand and manage these problems in the aggregate.

E.M. Jellinek, in his classic 1960 text, noted that the debate over the disease concept was plagued by too many definitions of alcoholism and too few definitions of disease. The continued proliferation of terms and their unclear meanings (alcohol/drug dependence/abuse/addiction/ problems, chemical dependency, substance abuse/misuse, disease, illness, sickness, malady, condition, habit) has created a virtual Tower of Babel within the on-going disease concept debate. To transcend the unproductive rhetorical excesses of this debate, a basic vocabulary of words and meanings must be forged.

One of the first definitions needed is that of *disease*. The addiction field must follow the rest of medicine in moving away from the depiction of disease as an entity to an understanding of disease as a metaphor. “Disease” is a *word* and an *idea* used to convey substantial, deteriorating changes in the structure and function of the human body and the accompanying deterioration in biopsychosocial functioning. To suggest that disease is a metaphor does not diminish the devastating reality that the term depicts, but it does suggest that this reality may constitute a process rather than a “thing.”

Alcoholism to Addiction

The new disease concept will shift from an alcoholism model to a more encompassing addiction model. It will define the boundaries of its application to particular drugs, declaring the concept’s relevance or misapplication to tobacco, opiates, cocaine and other stimulants, cannabis, and other licit and illicit psychoactive drugs. It will incorporate the latest advances in biomedicine to answer the question of whether personal vulnerability to addiction is drug-specific, drug-category specific, or expansive across a range of substances and experiences.

Boundary Integrity

The new disease concept will carefully map its conceptual boundaries,

defining the conditions and circumstances to which it should and should not be applied. The concern here is that a concept can be diluted, distorted, over-extended, commercially exploited, and over-used to the point that its utility is destroyed. The history of the concept of “co-dependency” provides a vivid example of what can happen under such circumstances. If the concept of co-dependency taught us anything as a field it is that when a concept begins to be applied to everything, it ceases to have meaning applied to anything.

The area of greatest trouble is the application of the concept of *addiction* and *addictive disease* to include *process addictions*--harmful relationships with food, relationships, sex, work, gambling, etc. It is the “etc.” that is particularly problematic. Americans already speak of being “addicted” to everything from bowling to television shows, self-describe themselves as “chocaholics,” “shopaholics” and every other kind of “aholic,” and apply the term “disease” to everything from violence to the use of profanity. The new disease concept will carefully re-establish and then guard its boundaries to prevent its continued over-extension and financial exploitation. To draw this boundary will require nothing short of defining the very essence of addiction and its roots.

Addictions versus Problems

The new disease concept will place alcoholism/addiction within a larger umbrella of alcohol- and other drug-related problems. The consumption of alcohol and other drugs contributes to a large spectrum of personal and social problems: fetal drug exposure, drug-impaired driving, drug-influenced crime and violence, and underage and binge drinking, to name just a few. An undefined portion of these problems are not the product of alcoholism and other drug addictions, do not constitute “disease” states, and should not have a traditional disease model of intervention applied to them.

The new disease model will seek to delineate alcohol and other drug “problems” from alcohol and other drug “addictions” and distinguish the prevention and intervention strategies that should be applied to each. It will seek to clearly specify the conditions that must be present to declare the presence of “alcoholism” or “addiction” and further argue (in the tradition of E.M. Jellinek) that an AOD problem be declared a “disease” if, and only, if certain specified conditions are present.

The field of professionally directed addiction treatment cannot have it both ways. It cannot (without great harm to itself and its clients) continue to clinically define alcoholism and addiction in narrow terms and then, for reasons of

professional and institutional gain, misapply this narrow model to an ever-expanding array of drug-related and non-drug-related problems. If the field continues to rely solely on a narrowly prescribed addiction intervention model, then ethically it must refuse to treat the wider pool of individuals with AOD problems for whom this model is inappropriate and potentially harmful. If the field embraces the larger spectrum of people with AOD (and other) problems within its purview (which it has), then it must significantly expand its potential treatment goals and intervention technologies (which it has not).

The new disease concept will acknowledge the differences in these populations and create a wider menu of treatment goals and technologies that can be selectively applied to these different but overlapping populations.

Disease Variability

The new disease concept will portray addiction as a cluster of disorders that spring from multiple, interacting etiological influences and that vary considerably in their onset, course, and outcome. This refined concept will incorporate rather than deny existing research on etiological factors, pattern variability and outcome variability.

The new disease concept will create taxonomies that delineate the clinical subpopulations that make up these divergent patterns and will move to a much more sophisticated approach to differential diagnosis and individualized treatment/recovery planning. To move the disease concept in this direction is not a call to break tradition but a call to return to earlier traditions, from the 19th century inebriety specialists understanding of “diseases of inebriety” to Jellinek’s “alcoholisms.”

The new disease concept will, for example, proclaim within its framework that:

- addiction is not caused solely by genetic or biological factors but by multiple interacting factors, a status that places it squarely within the rubric of other chronic diseases,
- not all addictions are progressive (accelerating), some remain stable but enduring while others decelerate, just like many other chronic diseases,
- patterns of spontaneous remission and maturing out exist in addiction just as they do with many other chronic diseases, and
- the movement from an AOD problem to a level of continued alcohol

and drug use below the priming dose of problem activation is common in those with transient AOD problems but rare in those with patterns of severe and persistent addiction.

Determining just how common or how rare these variations are is an important question, one that needs to be moved from the arena of rhetorical debate to the arena of research. The “truth” on many of these contentious issues will be found in the space between the polarized positions of the most rabid disease advocates and critics.

Comorbidity

The new disease concept will define the complex inter-relationships between addiction and other acute and chronic disorders and champion integrated models of care for the multiple problem client/family. Alcoholism and other addictions can result from and contribute to other diseases. These comorbid conditions interact synergistically to debilitate, compromise recovery, and shorten lives. The longer addictive disease is active, the higher the risk for collateral disorders. A major challenge for the new disease concept will be to define the interaction between addiction and other disorders, discover strategies to prevent the onset and severity of comorbid conditions, and generate principles for the co-management of these conditions.

Multiple problem clients have become the norm in addiction treatment agencies across the country. These clients, many with long and complicated service histories, have not fared well in America’s categorically segregated service system. They frequently report histories of service exclusion, service extrusion, premature service disengagement, repeated episodes of relapse and treatment re-engagement, and even treatment episodes that were more harmful than beneficial. The new disease concept will provide a framework through which the needs of these clients can be met by strategically integrating the resources of multiple formal (professional) and indigenous helping institutions.

Role of Human Will

The new disease concept of alcoholism /addiction will define the role human will and personal responsibility play in the onset, course, and outcome of AOD problems and of alcoholism/addiction. Are alcoholics/addicts responsible moral agents who perpetrate acts of mayhem on themselves, their families and their

communities, or are they victims of a disorder that undermines their values and best intentions? What is the effect of the answer to this question upon the individual alcoholic/addict and upon the society in which he or she resides?

The new disease concept will provide a more accurate and nuanced answer to this primary question, not in terms of whether addiction is or is not a choice, but by depicting how the freedom to use or not use varies across clinical populations and within the same individual across the stages of drug use, addiction, and recovery.

It will be helpful to plot the degree of freedom one has to use or not use across the stages of problem development and problem resolution. Alcohol/drug use, addiction and recovery are best portrayed not in terms of complete control and complete lack of control but in terms of degrees of diminishment or enhancement of voluntary control. Once educated, each person has a responsibility to:

- manage his or her own health,
- recognize his or her potential vulnerability for AOD disorders,
- act proactively to prevent the onset of such disorders,
- recognize the presence of such disorders, and
- act decisively to arrest and manage the disorder.

Most chronic diseases are characterized by risk/resiliency factors related to daily diet, work habits, exercise, sleep, stress management, psychoactive drug consumption, exposure to environmental toxins, specifically contraindicated (high risk) behaviors, personal beliefs, and social support.

The new disease concept will emphasize the responsibility of the individual to actively manage these global health issues as an integral part of the daily process of long term recovery.

The Variety of Recovery Experiences

The new disease concept will celebrate the variety of styles and pathways of long term recovery management. Ernest Kurtz, the noted author of *Not-God: A History of Alcoholics Anonymous*, recently observed that if he were to write a follow-up to his original work, he would entitle it “Varieties of A.A. Experience.” What has become clear in recent decades is the enormous variety of ways that people are resolving AOD-related problems. This reflects not only the growing varieties of 12-Step group experience that Kurtz suggests, but the equally significant proliferation in alternative support structures, alternative treatment approaches, and solo (without aid of treatment or mutual aid) recovery

experiences.

What will flow out of the new disease concept is not “a program” that everyone goes through, but a menu of professionally-directed interventions, recovery support services, mutual aid groups, indigenous healers/institutions, and self-engineered (potentially manual-guided) programs of recovery that individuals can select for personal and cultural fit.

The challenge for the treatment professional will be to remain continually aware of the evolving choices on this menu and to help match menu items to the needs of their individual clients. Rather than be defensive about the fact that people are finding a variety of ways to resolve AOD problems, it is time we celebrated the growing diversity of the culture of recovery.

Recovery Management

The new disease concept will view addiction as a chronic rather than acute disorder and incorporate the principles of chronic disease management that are being used to understand and manage other chronic disorders. Alcoholism and other addictions have long been characterized as chronic diseases, but their treatment has been marked by what is essentially an acute care model of intervention.

All too often we respond to life-impairing and life-threatening episodes of chronic addiction disease with sequential episodes of brief, expensive, emergency-oriented interventions that do little to alter neither the overall course of addiction nor its personal and social costs.

The new disease concept will focus on interventions that strengthen and extend the length of remission periods, reduce the number of relapse events, reduce the intensity and duration of relapse episodes, and reduce the personal and social costs associated with such episodes.

It will achieve this by applying to the management of addiction recovery not just the new breakthroughs in addiction science, but also the new principles and techniques that are being successfully used to manage other chronic diseases.

Viewing recovery through this much longer time lens will require that the helper-client relationship move from a brief, expert-focused model of intervention to a partnership model of long term disease/recovery management.

A Final Word

The addiction disease concept will continue to face two quite different

litmus tests: 1) Is the disease concept true? 2) Does the disease concept work? Answering these will require achieving some degree of consensus as a professional field and as a society about how we know something is true and how we know whether something works, tasks not as simple as they might seem. That the concept of “disease” has provided alcoholics an organizing metaphor for personal change and provided America a framework for organizing a response to her alcohol-related problems is undeniable.

However, there is still a question of whether additional or alternative metaphors would reach a larger number of those suffering from severe AOD-related problems and provide a more effective framework for organizing broad social responses to the prevention and management of AOD-related problems.

I believe that the disease concept of addiction has “worked” at personal, professional and community levels within particular historical periods and within particular cultural contexts. However, it is unlikely to survive as the dominant “governing image” for AOD problems unless it is able to continuously incorporate the following: 1) the new findings of addiction science, 2) major elements of the emerging public health model, and 3) the ever-accumulating lessons of clinical and recovery experience.

Nowhere is the gap between clinical research and clinical practice wider nor where there are more contradictions between treatment philosophies and treatment practices than in the application of the disease concept to the treatment of AOD problems. The fate of the disease concept rests in great part on closing these gaps and resolving these contradictions.

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