

Why It Doesn't Make Sense To Call Addiction A Disease

We frequently hear from people who say: "I drink too much sometimes, but I don't think I'm an alcoholic. And I don't want to stand up and talk about myself in front of a group. Is there any other way I can change the way I drink?"

"I'm overweight, but I understand that people are born to be fat and there's not much you can do about it. I know I've tried to lose weight a million times and failed. Does this mean I'm doomed to be overweight?"

"I saw an ad saying the only way to beat your addiction to nicotine is by going to a doctor. Is that really true? Don't people ever quit smoking on their own?"

"My father was an alcoholic. Does that mean I'm likely to become an alcoholic myself? Should I play it safe and quit drinking altogether? A friend of mine joined a 'Children of Alcoholics' group, even though she's never even been drunk. Should I join such a group? And what about my kids?"

"My son was caught smoking marijuana. Now I'm told that, unless I place him in an expensive residential treatment program, he could escalate his drug use and die. I don't have the money for this but, of course, if I have to save his life I'll mortgage the house!"

People are much concerned about bad habits (which sometimes reach life-consuming proportions) that they'd like to do something about—drinking, smoking, overeating, taking drugs, gambling, overspending, or even compulsive romancing. We hear more and more that every one of these things is a disease, and that we must go to treatment centers or join twelve-step support groups like Alcoholics Anonymous or Gamblers Anonymous in order to change any of these behaviors. Is there really no other way to change a powerful habit than to enter treatment for a disease? Do personal initiative, willpower, or just maturing and developing a more rewarding life have anything to do with people's ability to overcome addictive habits?

As children, as spouses, as parents, as employers, as consumers, and as citizens we must struggle to understand and master the destructive potential of drugs, alcohol, Gambling, and related addictions. The kinds of questions so many people face today include: What do we do if we discover our children are smoking marijuana, or worse? Should we put them in a treatment center that will teach them they are chemically dependent for life? How can we tell if co-workers, employees, and friends are secretly addicts or alcoholics? What is the most appropriate way to react to people who drink too much or do anything that harms themselves and others? Furthermore, as a society, how should we deal with these problems? Are our incessant wars on drugs really going to have the positive impact the generals in these wars always claim? Or is there some more sensible or direct way to reduce the damage people do to themselves through their uncontrollable habits? Rather than arrest drug users, can we treat addicts so that they stop using drugs? And if we expand the treatment for all the addictions we have seen—like shopping and smoking and overeating and sexual behavior—who will pay for all this treatment? Finally, does addiction diminish people's judgment so that they can't be held accountable for their behavior, or for crimes and financial excesses they commit while addicted?

What you will read here is not the same as what you see and hear in newspapers and magazines, on television, in addiction treatment centers, in twelve-step groups, and in most physicians' and therapists' offices or what your children are learning in school. For in its desperate search for a way out of the convulsions caused by drug abuse and addiction, our society has seized upon a simple, seductive, but false answer that this program disputes. What we say is, indeed, so different from most things you hear that we have provided extensive documentation at the end of this information.

The simple but incorrect answer we constantly hear is expressed by the familiar statement, "Alcoholism is a disease." In other words, we can treat away these problems in a medical setting. This viewpoint has proved so appealing that it has been adopted by professional organizations and government agencies as well as by groups like Alcoholics Anonymous and Gamblers Anonymous. And now the "disease" label is applied not only to alcoholism, drug addiction, cigarette smoking, and overeating, but also to gambling, compulsive shopping, desperate romantic attachments, and even committing rape or killing one's newborn child! A.A.'s image of "powerlessness over alcohol" is being extended to everything that people feel they are unable to resist or control.

But what lies behind the claim that alcoholism and other addictions are diseases? How accurate is it? What evidence supports it? Most important, what good does it do us to believe it? Will it really help you or someone you care about to overcome an addiction? This book will show that the answer is no—that, in fact, it may do more harm than good. What's wrong with calling a tenacious and destructive habit a disease? Three things:

1. It isn't true.
2. It doesn't help most people (and even those it does help might succeed just as well in some less costly, less limiting way).
3. It prevents us from doing things that really would help.

Here we will summarize what the disease model says, why it is wrong, and why it is harmful. As you will see, there is no good reason to label yourself or people you know as forever marked by an addictive "disease." Challenging this useless folklore is the first step toward understanding addiction and doing something about it.

Then we will present an alternative way of thinking about and dealing with addiction called the Life Process Program. The accompanying table previews the major differences between the Life Process Program and the disease model of addiction.

Myths Versus Realities

To highlight some of the surprising facts we will reveal, here are some common beliefs about various addictions:

- A person needs medical treatment or a program like Smokenders to quit smoking.
- Attending Alcoholics Anonymous meetings is the most effective way for alcoholics to stop drinking.
- Once a compulsive gambler has this disease they are powerless over this illness and there is no cure.

- Nearly all regular cocaine users become addicted.
- Very few people who have a drinking problem can ever drink in a normal, controlled manner.
- Drunk drivers who undergo treatment for alcoholism are less likely to repeat the offense than those who receive normal judicial penalties such as license suspension.
- Most people with an alcoholic parent become alcoholics themselves.
- Most people who are binge drinkers in their twenties go on to become alcoholics.
- Most of the American soldiers who were addicted to heroin in Vietnam remained addicted or became addicted again after they returned home.
- The fact that alcoholism runs in families means that it is an inherited disease.
- Fat children, because they have inherited their obesity, are more likely to be fat in later life than are people who become fat as adults.

Actually, the best scientific evidence available today indicates that none of these statements is true. Such specific misconceptions grow out of a foundation of false assumptions about the nature of addiction generally.

Ten Assumptions that Distinguish the Life Process Program from the Disease Model

DISEASE MODEL

LIFE PROCESS PROGRAM

1. Addiction is inbred and biological.

1. Addiction is a way of coping with yourself and your world.

2. The solution is medical treatment and membership in spiritual groups such as A.A.

2. The solution requires self-awareness, new coping skills, and changing your environment.

3. Addiction is all-or-nothing; you are or you aren't an addict.

3. Addiction is a continuum; your behavior is more or less addicted.

4. Addiction is permanent and you can relapse at any moment.

4. Addiction can be outgrown.

5. Addicts are "in denial" and must be forced to acknowledge they have a disease.

5. You should identify problems and solutions in ways that work for you.

6. The recovering addict/alcoholic is the expert on addiction.

6. Those without an addiction problem are the best models.

7. Addiction is a "primary" disease.

7. Addiction stems from other life problems you have.

8. Your main associates must be other recovering addicts.

8. You should associate with a normal range of people.

9. You must accept the disease philosophy to recover.

9. Getting better is not a matter of believing a dogma.

10. Surrendering to a higher power is the key to recovery.

10. You must develop your own power to get better.

What Is the Disease Model of Addiction?

At first, it seems hard to understand what is meant by saying that something a person does (such as drinking alcohol or, especially, gambling) is a disease. Habitual, voluntary behavior of this sort does not resemble what we normally think of as a disease, like cancer or diabetes. What is more, AA, hospital programs for alcoholism, GA don't actually treat any biological causes of alcoholism. After all the claims we have heard in the past decade about biological discoveries concerning alcoholism and addiction, not one of these findings has been translated into a reliable treatment used with many people. Instead, the same group discussions and exhortations that have been used for the last fifty years are employed in hospitals and treatment programs. Nor is any medical test used to determine whether someone is an alcoholic or addict, other than by assessing how much that person drinks, gambles et al. and the consequences of that behavior. If you went to a hospital and they did a PET scan of you brain and declared, "You're a gambling addict!", you might sue them for malpractice.

There is, however, a standard way those who claim addiction is a disease *describe* addictive diseases. This description has been developed by groups such as Alcoholics Anonymous, by the medical profession, and by various popularizers of the idea that alcoholism is a disease. What they say is in every regard wrong. When they tell you that you have the "disease" of alcoholism, "chemical dependency," obesity, compulsive gambling, or whatever, this is what they mean:

The basis of the disease is inbred and/or biological.

There is no need to look for the causes of the disease in your personal problems, the people you spend time with, the situations you find yourself in, or your ethnic or cultural background. Addiction is bred into you from birth or early childhood. Your current experience of life has nothing to do with it; nothing you can do makes you either more or less likely to become addicted.

It involves complete loss of control over your behavior.

Once involved in your addiction, you are utterly at its mercy. You cannot choose whether, or how much, to lose yourself in the involvement. No matter how costly it may be in a given situation, you will go all the way. You cannot make reasonable, responsible choices about something to which you are addicted.

Addictions are forever.

An addictive disease is like diabetes—it stays with you as long as you live. The mysterious bodily or psychic deficiency that lies at the root of addiction can never be remedied, and you can never safely expose yourself to the substance to which you were addicted. Once an addict, always an addict.

It inevitably expands until it takes over and destroys your life.

"Irreversible progression" is a hallmark of addictive diseases as they are conceived today. The addiction grows and grows until it devours you, like AIDS or cancer. No rewards, no punishments, not even the most momentous developments in your life can stay its course, unless you completely swear off the addictive substance or activity.

If you say you don't have it, that's when they really know you have it.

According to this “Catch-22” of the disease theory, anyone suspected of having an addictive disease who insists that he or she *doesn't* have the disease is displaying the disease symptom of “denial.” In this way, the “disease” label is like a web that traps a person more firmly the harder the person fights to get out of it.

It requires medical and/or “spiritual” treatment.

Thinking you can cure your addiction through willpower, changes in your life circumstances, or personal growth is a delusion (like denial), according to disease-theory proponents. Addiction is a disease of the body that can be controlled only by never-ending medical treatments. It is also a disease of the soul requiring lifetime membership in a twelve-step support group like Alcoholics Anonymous. Why supposed medical treatment consists mainly of going to group meetings and why people can't develop their own spiritual approaches to life if they choose are questions disease theory boosters ignore.

Your kids are going to get it, too.

Since addiction is an inherited disease, the children of addicts are considered at high risk for developing the same disease—*no matter what you or they do or how careful you are*. Logical deductions from this viewpoint are that you should have your kids tested for their genetic predisposition to alcoholism or addiction before they start school, or that you should simply teach them never to touch a drop of alcohol or expose themselves to whatever your addiction is. Obviously, this approach presents special difficulties in dealing with addictions to eating, shopping, and making love.

Where did these notions come from—notions that, when examined in the clear light of day, often seem quite bizarre and contrary to common experience? The disease theory takes a set of precepts that were made up by and about a small group of severe, long-term alcoholics in the 1930s and applies them inappropriately to people with a wide range of drinking and other life problems. The original members of Alcoholics Anonymous, realizing they would soon die if they did not give up alcohol, adopted wholesale the dogma of the nineteenth century temperance movement. The one major difference was that the A.A. members said drinking was a disease only for them, and not for everyone who drank—therefore not everyone needed to eschew “demon rum,” as temperance advocates had insisted.

The AA model has struck a responsive chord among Americans. Obviously, with the rejection of Prohibition, the United States had decided against a national policy that everyone should abstain from drinking. Yet American society continues even today to show a deep unease about alcohol and about intoxication, which many people seek even while fearing its disturbing effects. The main change since temperance times is that we now apply this same thinking to a host of things besides alcohol—everything that people can do compulsively and destructively. Given our national preoccupation with addiction, we have been drawn to the “old-time religion” of temperance, as represented by AA, now cloaked in the modern language of medicine and the neurosciences. But, as the Life Process Program © will make clear, the operative assumptions about addiction have *never* arisen directly from biological sciences. Rather, they have been superimposed on scientific research, much of which directly *contradicts* the assumptions of the disease theory.

Why the Disease Model Is Wrong

Every major tenet of the “disease” view of addiction is refuted both by scientific research and by everyday observation. This is true even for alcoholism and drug addiction, let alone the many other behaviors that plainly have little to do with biology and medicine.

No biological or genetic mechanisms have been identified that account for addictive behavior.

Even for alcoholism, the evidence for genetic inheritance is minor. At one point we seemed to hear regular announcements that scientists have discovered a gene that causes alcoholism or addiction. But this idea is no longer proposed the way it was. Sure, people still feel that addiction may be inherited. But no one speaks about a gene for addiction—there’s a recognition that addiction is just too complicated to be contained within a simple inherited process. Even if a number of genes (which is now how such thinking runs today) are found to influence addiction, would the same genes cause alcoholism and drug addiction? What about smoking? Would the same genes also *cause* compulsive gambling and overeating? If so, this would mean that everyone with *any* of these addictions has this genetic inheritance. Indeed, given the large number of addictive problems we’ve uncovered, it would seem that half of the population has some form of these addiction genes.

How could an addiction like smoking be genetic? Why are some types of people more likely to smoke than others (about half of waitresses and car salesmen smoke, compared with about a tenth of lawyers and doctors)? And does believing that an addiction like smoking is genetic help the person quit (are all those smokers who quit not “genetically” addicted)? Returning to alcohol, are people really predestined biologically to become alcoholics and thus to become AA members? Think about the rock group Aerosmith: all five members of this group joined AA at once, just as they once all drank and took drugs together. How unlikely a coincidence it is that five unrelated people with the alcoholic/addictive inheritance should run into one another and form a band!

The idea that genes *make* you become alcoholic cannot possibly help us understand how people develop drinking problems over years, why they choose on so many occasions to go out drinking, how they become members of heavy-drinking groups, and how drinkers are so influenced by the circumstances of their lives. Genes may make a person unusually sensitive to the physiological effects of alcohol; a person can find drinking extremely relaxing or enjoyable; but this says nothing about how the person drinks over the course of a lifetime. After all, some people say, “I never have more than one or two drinks at a time, because alcohol goes straight to my head.” And how much more true is this for people taking drugs like crack, which only some groups go in for. And why do more younger people become obese all the time, if obesity is inherited?

You will see here and in the following modules that whether people become—and remain—addicted has a lot more to do with the groups they come from and associate with, and from their beliefs and expectations about alcohol or drugs (or other activities), than from their biological makeup.[2] Often, people who become addicted set themselves up by investing a substance or an

experience with magical powers to transform their beings (“When I drink I’m really at ease”; “Drinking makes me attractive to people of the opposite sex”; “I only feel good about myself when I am buying clothing”; “Gambling rescues me from my hum-drum existence.”).[3] It is simply not within the chemical properties of alcohol or a drug, or the experience of activities like shopping and gambling, to offer people what they want and seek from an addiction.

People find these feelings in an addiction when they believe they can’t achieve the feelings they need in ordinary ways. Clearly, attitudes, values, and the opportunities people have in their lives have the most to do with whether a person has a significant risk for one type of addiction or another.

Addiction is not a “hot spot” in the brain.

In the last twenty years, our attention has shifted from genetics to neuroscience, as represented by Nora Volkow, director of the National Institute on Drug Abuse, who has become a media star with the meme, “Addiction is all about the dopamine.” This refers to a neurochemical that may be entailed in the pleasure centers of the brain, and which various drugs and activities stimulate.

On the one hand, focusing on dopamine and neurochemistry offers a chance to put a wide variety of addictions in the same bag, since eating, sex, gambling, shopping may all stimulate dopamine. And, so, decades after I wrote *Love and Addiction* with Archie Brodsky, where we said gambling and non-drug activities can be addictive, comes the American Psychiatric Association’s diagnostic manual to recognize gambling, and potentially many other things, as being addictive. Addiction is not due to drugs!

But this simply raises the same old specters. If everything and anything can be addictive, then what causes someone to become addicted, since we all do one or many of these things? In come deficiency models—perhaps some people don’t have enough dopamine production. But, then, why do people largely give up their addictions—like smoking and, as we shall see, alcoholism and drug addiction? The neurochemical model is no good for telling us about maturing out, the most common route out of addiction. It tells us primarily that we are (thank you Dr. Volkow) hopeless, unless and until we rely on an addiction doctor, like those in the newly-formed American Board of Addiction Medicine.

Volkow is fond of interviews (like one on *60 Minutes*) where she points out the certain places in the brain light up on brain scans when people take cocaine. Right—and so what? Why do some people continue to return to this state ad infinitum, some do it occasionally, and some do it intensely for a time, and then quit, or even cut back? Now that we know that similar (or other) parts of our brains light up when we have sex, or eat, or go shopping, or gamble, what stops us all from being permanently addicted. Volkow is fond of showing that, as we have long known, the brains of addicts light up even when not taking the drug from *seeing* the drug, or even locations where they took it. Yes, and so why did my Uncle Oscar—and many, many people you know, or perhaps you yourself—quit his (in Oscar’s case) four-pack-a-day habit in his early forties, after 25 years of smoking, and never smoke again?

People, like you, quit addictions when they want to, need to, have to, live out more important parts of their lives, and then they cope with urges to return to smoking, or gambling, or drugs, or alcohol—or cut back on shopping, or eating and, yes, even gambling, sex, and drugs. I testified at a murder trial where the defense’s position was that the man had killed because he had an irresistible need for cocaine which he could only get through stealing his dealer’s cocaine stash, which in order to do he would first have to kill the man (and, while he was at it, his girlfriend). Would you kill someone to go shopping?

The reason I ask is because the defense attorney asked me, “Are you going to tell me that since my mother quit smoking a dozen years ago, she hasn’t woken each and every morning wanting to smoke a cigarette?” And I replied, “Has she smoked again? (She hadn’t.) And if she really wanted a cigarette, would she kill someone to get it?” Or, we might ask, “Would your mother keep smoking if she knew she was deforming a fetus in her womb?” Because the answer, for more mothers and other people than for any recipient of psychiatric meds, the answer is often “no.”

People do not necessarily lose control of themselves whenever they are exposed to the object of their addiction.

On the contrary, many practice their addictions quite selectively. For example, military and religious personnel are often deprived of tobacco during training or on retreats, and business people realize they can’t smoke in certain rooms. Orthodox Jews who smoke heavily abstain from smoking on the Sabbath, showing that their religious values mean more to them than nicotine does.[4] Alcoholics in experiments routinely control their drinking when it is in their interest to do so—say, when they must leave a cozy room with television and companionship in order to get more to drink.[5] These variations occur in real life just as they do in the laboratory—for example, when people avoid drugs or cigarettes when they are with people who won’t tolerate those habits. When something they really care about is jeopardized if they continue to drink, smoke, or whatever, most people will stop or cut down accordingly.

Addiction usually does not last a lifetime.

“Once an addict, always an addict” is a pessimistic notion that is both wrong and harmful. It leaves people two choices: either you stay constantly addicted and miserable until you die; or you abstain for life while attending group meetings and viewing yourself as the perpetually “recovering” person. Sadly, a small number of people do die of their addictions; and another group succeeds in quitting drinking, drug taking, or whatever by maintaining the role of the recovering addict. But *most* people are more resilient and resourceful than that. Most people who have addictive habits moderate or eliminate these habits over the course of their lives. And they do it without having to say “I am an alcoholic” or “I am an overeater” or “I am a sex addict” as long as they live. Remember that, today, a majority of the adult Americans who have ever smoked have quit and nearly all did so without treatment.

Progression is not inevitable—it is the exception.

If the majority of people give up addictive habits, then the idea of “inevitable progression” doesn’t hold water. Calling addiction a “progressive disease” comes from looking at the few who *have* progressed to severe addiction and tracing the path by which they got there. The progression of addictive problems only *seems* inevitable after the fact. For example, the great majority of college overdrinkers, even those who black out at fraternity parties, become moderate drinkers in middle age.[6] When you consider that even most of the people who use narcotics and cocaine do not end up addicted, you can see that drug-and-alcohol use patterns are many and varied, even when a person uses a substance abusively for a time. And, now, the most comprehensive government research shows that the majority of alcoholics cut back or quit on their own to achieve full recovery.

Treatment is no panacea.

Contrary to all the advertising we hear, treatment for addictions is often no more effective than letting addiction and recovery take their natural course. The vast majority of people who have given up addictions, including at one point more than 90 percent of the forty-four million Americans who have quit smoking[7] (although that percentage has decreased with the constant marketing of nicotine gums and patches and drug therapies), along with the large majority of alcoholics and drug addicts, have done so on their own. This does not mean that treatment for addictions cannot work—research has shown that some forms of treatment are effective. But the ones that are more effective are not the ones that have become popular in the United States.[8] You can outgrow an addictive habit on your own or in therapy, but either way the principles of the Life Process Program are the same.

What about joining support groups such as Alcoholics Anonymous or Gamblers Anonymous? Here, too, research reveals the opposite of what we have been led to believe. Support groups can be valuable community resources for those who seek help in certain types of group experiences and rituals. But the best we can say about these groups is that they work for those for whom they work. Ask a twelve-step expert these questions: (1) What percentage of all alcoholics really give AA a go? (2) Of all of those who attend AA for at least some time, what percent remain in the group and quit drinking permanently? The answer to each this expert may give (because it is correct) is 10 percent. Which adds up to one in a hundred succeeding via the twelve-step route. We now know, the vast majority of those who achieve full recovery from alcoholism and addictions of all sorts do so without a support group or any kind of treatment. This means that it is *normal* not to succeed via the twelve steps, and that AA, GA, etc. don’t work for most addicts. If they did, we would have solved the alcoholism-addiction problem long ago, and Nora Volkow wouldn’t be selling her wares. There is no scientific evidence that AA or twelve-step treatments work better than other approaches when randomly selected addicts are assigned to them or other treatments. In fact, the evidence is that the people who are now often compelled to attend AA—after being arrested for drunk driving or being sent by a company Employee Assistance Program—do worse than those who are left on their own.[9]

How can we reconcile this finding with the glowing testimonials we hear about AA, GA, etc.? The people we see in these groups are the ones who like it, find it helpful, and stick it out. But

there are many more (90%, as we have seen) who don't go to them or who drop out. And as we show below, those who seriously try to stop an addiction on their own are often more likely to succeed than those who rely on a group. But why is it—if so many more people succeed on their own—that we don't hear more from self-curiers? It's just not something that most people talk about. To take one prominent example, remember when Drew Barrymore was featured, age 12, on the cover of *People* as America's youngest addict, and at age 14 after two rehab stints and a suicide attempt wrote *Little Girl Lost* in 1990? Why wasn't it worth a cover story when *People* announced 25 years later, in 2012 (June 4), “Drew Barrymore: She's a Vintner. Barrymore, 37, unveiled her eponymous pinot grigio reflecting the star's taste for fruity whites,” but only a glancing picture of Barrymore in her winery on page 28? Opening a winery just isn't front-page news, although reflecting on *People*'s view of addiction ought to have been, at least in our view.

These, then, are the key fallacies of the popularly held view of addiction. Even generally well-informed people may be astonished that we contradict such widely held beliefs. All of our refutations of conventional wisdom are carefully documented in the notes and references at the end of these sections. But you don't need to read scholarly articles and scientific reports to test the accuracy of what we say. Just check it out against your own experience and observation. Don't you know anyone who used to drink excessively, at times uncontrollably, but who no longer drinks at all or now drinks in a normal, appropriate manner? Obviously, most people who used to drink excessively but who have now cut back (or even quit) do not attend meetings where they must rise and declare, “I am an alcoholic.” How many people of all ages do you know who quit smoking? How many of them did it by going through a medical program or joining a support group, and how many finally just decided to quit and made good on that resolve? What happened to all the people you knew who used illegal drugs in college, some quite heavily? How many of them are “chemically dependent” now? If we simply examine the cases of most of those we are close to personally, we will see how addictions usually do not follow the disease course.

Why the Disease Model Doesn't Work— Why It Even Does More Harm than Good

The assumption that calling addiction a “disease” actually helps people crumbles when subjected to critical scrutiny. Some people feel comfortable thinking of their addiction as a disease and are able to function better on this basis *for a time*. But whatever short-term benefits medical, disease-oriented treatment produces are double-edged even for the individuals who claim it has helped them. Many of the most “successful” recipients of disease treatment might achieve a real breakthrough by learning to think about addiction differently. Meanwhile, for the *majority* of people, the disadvantages of the disease approach clearly outweigh the advantages from the start.

The disadvantages of the disease approach are that it:

- attacks people's feelings of personal control and can thus become a self-fulfilling prophecy;
- makes mountains out of molehills, since it fails to differentiate between the worst alcoholics and addicts and those with minor substance-use dependence;
- stigmatizes people—in their own minds—for life;
- interrupts normal maturation for the young, for whom this approach is completely inappropriate;

- holds up as models for drinking and drug use and gambling the people who have shown the least capacity to manage their lives;
- isolates addiction as a problem from the rest of the addict's life;
- limits people's human contacts primarily to other recovering addicts, who only reinforce their preoccupation with their addictive problem;
- dispenses a rigid program of therapy that is founded—in the words of the director of the government's National Institute on Alcohol Abuse and Alcoholism (NIAAA)—“on hunch, not evidence, and not on science,”[11] while attacking more effective therapies.

How can a type of therapy or support that so many people believe in and swear by actually do more harm than good? To illustrate this point, consider the case of a famous psychiatrist who evaluated his hospital's alcoholism program—one he felt was among the most outstanding in the world. This program first detoxified the alcoholic in the hospital, then required AA attendance, and finally actively followed patients' progress with an outreach counseling program. When the psychiatrist running the program, Dr. George Vaillant, evaluated how well his patients were doing two years and eight years after treatment, however, he found they had fared about as well as comparable alcoholics who received no treatment at all![12]

How could Vaillant have been so wrong as to think his patients were doing phenomenally well, when actually they were doing no better than if he had left them alone completely? Naturally, he *wanted* to think it worked. But his research prevented his rose-colored views from distorting the actual results of his treatment. When he counted *all* his patients, not just his successes, when he scrutinized and verified what they were telling him in order to see exactly how well they were doing, and when he compared them with alcoholics out on their own instead of just assuming that all these people died without the help of treatment like his, Vaillant found that his expensive hospital treatment was close to useless.

Very few people in the treatment industry or in A.A. are as scrupulous as is Vaillant. When we hear from A.A. boosters, they tell us only about those who have stuck with the program and are currently sober. The same is true of treatment programs. They parade their best stars up front. We don't hear about all their failures. Yet Vaillant, in a book that is cited as the *major source of support for the benefits of treating alcoholics according to the disease model*, concluded as follows: “If treatment as we currently understand it does not seem more effective than the natural healing processes, then we need to understand those healing processes better.”[13] Indeed, Vaillant concluded that “it may be easier for improper treatment to retard recovery than for proper treatment to hasten it.”[14]

What are the dangers of this kind of disease treatment? Here are explanations of its disadvantages:

It sets people up for failure.

All disease treatments emphasize how much out of control “patients” are, and what a delusion it is for them to feel they can exert any control over their addictions. Is it possible that such a message can do more harm than good? William Miller and Reid Hester, reviewing all the comparative studies on treatment for alcoholism, made a surprising finding: in the only two

studies in which alcoholics were randomly assigned either to AA, to other forms of treatment, or to no treatment, those assigned to AA did no better *or actually suffered more relapse* than those who received other treatment or who weren't treated at all![15] Intrigued by this outcome, I wrote George Vaillant and asked him whether subjects he studied who abstained without entering formal treatment did better if they joined AA. Vaillant's data showed that alcoholics in his study who joined AA were *less likely* to maintain their abstinence.[16]

Why would people be more likely to relapse if they entered AA than if they quit drinking on their own? There are several reasons. For one, people who enter AA are told they cannot succeed on their own. Therefore, if they should stop attending AA, many are convinced that they will soon resume alcoholic drinking.

AA and disease treatments are especially defeatist in dealing with relapse. Accepting the disease-oriented philosophy of inevitable loss of control thus makes it more likely that the alcoholic will binge if he or she ever has a drink. Yet, Vaillant found, nearly all alcoholics will drink again at some time.

These things are equally true of other twelve-step groups like GA. Telling people they can't make it without their support group, or that if they slip and gamble again—no matter how many days, weeks, months, or years it's been—they are headed straight back to the bottom of their addictive pit, is just not helpful, and is more likely to hurt people.

It makes matters worse than they are.

Can attending AA or going into addiction treatment really *cause* people to develop some of their alcoholism symptoms? In his book *Becoming Alcoholic*, sociologist David Rudy reports on the time he spent observing AA meetings. Rudy found that most people had to *learn* their role as alcoholics. An important "rite of passage" is the first time members tell their story for the group, beginning by acknowledging, "I am an alcoholic." In Rudy's words, the alcoholic's tale "is made up of two parts: a story about how bad it was before AA and a story about how good it is now." [17] This presentation is warmly greeted by the member's sponsor in AA, and the entire membership responds with enthusiastic acceptance of the convert.

When alcoholics introduce their experiences and symptoms in or treatment, the group or therapist homogenizes them through interpretation and clarification. For example, most people who enter have not had blackouts, which are more typical of long-term alcoholics than of the younger drinkers now flooding into treatment and AA. But blackouts are taken as the badge of alcoholism, and according to Rudy, "members learn the importance of blackouts as a behavior that verifies their alcoholism, and an indeterminable number of members who may not have had blackouts report them." Rudy continues:

When newcomers to A.A. claim that they cannot remember if they had any blackouts or not, other members use this claim as evidence of the event in question. As one member put it to a newcomer: "The reason you can't remember is because alcohol fogs your brain. If it fogs your brain now after not drinking for a few days it must have fogged your brain before. See, you must have had blackouts then." [18]

A large part of alcoholism and drug treatment in America consists of group meetings where alcoholics or addicts “confront” one another and their problems. Newcomers who don’t report the correct symptoms are treated with knowing condescension or are actively hazed—sometimes quite abusively—until they “get” and repeat the party line. When Dwight Gooden entered the alcoholism-and-cocaine program at the Smithers Alcoholism Center, he described being assailed by his fellow residents there during the constant group-therapy sessions. “My stories weren’t as good as theirs. . . . They said, ‘C’mon, man, you’re lying.’ They didn’t believe me. . . . I cried a lot before I went to bed at night.”[19]

After he left the Betty Ford Center, Chevy Chase reported that he had often been angry at the counselors, who heckled the residents mercilessly, constantly denigrating them and claiming they had been living worthless lives. Does all this sound like good therapy technique? It is simple common sense that belief in your personal value and your own strength is superior to having these things denigrated for getting your life under control.

So, too, attending GA means you have to be a gambling addict. And if your symptoms aren’t severe enough—like if you have walked away from the gambling table or shown other resistance to your “disease” on your own—you’ll be discouraged, even put down, for claiming these things. But these are the very internal signs you should rely on to tell you that you *can* get better.

It stigmatizes people for life.

The disease model puts a label on you that you can never outgrow. Once diseased, always diseased. The effects of this defeatist view are especially tragic—and unjust—in the case of people to whom the “disease” label is most inappropriately applied in the first place: teenage binge drinkers, most drunk drivers, “adult children of alcoholics,” recreational drug users discovered through drug tests, and—in areas not involving drugs or alcohol—overweight adolescents or “hyperactive” or “learning-disabled” children. You know, sometimes you do things when you’re younger, including stupid gambling splurges, that just don’t have to be a permanent part of your personality.

It brutalizes and brainwashes the young.

The largest single age group of people undergoing hospital treatment today for chemical dependency, eating disorders, depression, and now gambling is adolescents. AA and other twelve-step members are much younger today, on average, than when the fellowship was founded by a group of men with serious, lifelong drinking problems. But few of these young people meet clinical standards for addiction. Indeed, numerous cases have been identified in which young people have been hospitalized for smoking marijuana or even for being *suspected* of using drugs. When one such case was revealed on national television, an unusually forthright consultant for the National Association for Alcoholism Treatment Programs confessed, “I’m afraid this happens far more than people in the field want to admit; it’s something of a scandal.”[20]

Meanwhile, AA and twelve-step groups now pervade high-school and college campuses. What is the impact of treatment that forces teenagers and young adults to take on the identity of addicts at such an early age?

Young people are warned that their substance abuse is a permanent trait, even though we have seen that a large majority will outgrow substance-abuse and other addictive problems as they mature. Presenting this message to the young can only *prolong* or exacerbate these problems, since it denies their own capacity for change and forces them to believe that *any exposure to their problem, drinking or otherwise, any time for the rest of their lives will lead them back to excess and addiction.*

Young treatment grads who constantly relapse and return to treatment are the norm. Of course, the relapses are then attributed to their “disease” and to their failure to heed the treatment’s warning to abstain forever.

These programs fairly frequently involve emotional abuse. Such “treatments” for children include “refusing to allow them to wear street clothes, keeping them in isolation for prolonged periods, or forcing them to wear self-derogatory signs, engage in other humiliation rituals . . . , or submit to intense and prolonged group confrontation” all of which, psychologists believe, “may destroy the youngsters’ already fragile self-esteem.”[21] When we describe these experiences, treatment specialists often argue in response, “Well, what if the kids would end up *dead* if we didn’t do this to them?” In other words, to object to these programs is likened to promoting addiction leading to death. Certainly, it is crucial to prevent children from harming themselves, and it can be worthwhile to remove children from a problem home, whether through a residential program or a visit to a sympathetic relative. But brainwashing, emotional blackmail, denigration, and psychological torture *never* work, except to make people so unsure of who they are or what they value that they will temporarily consent to the demands of those in charge.

Worst of all, therapies that were devised for the most incorrigible children—though they don’t benefit even these unfortunate kids have been spreading down the ladder to more and more children whose behavior represents typical adolescent exploration and insubordination. Parents are then confronted over whether they want to “save” their kids or allow them to die, as though the latter were the normal outcome of adolescence. The threat of their children’s dying is then used as emotional blackmail to make parents accept the sacrifices necessary to place their children in expensive residential treatment programs.

It presents the alcoholic or addict as someone to emulate.

Prominent graduates of treatment programs, especially athletes and entertainment figures, go on to lecture to others about addiction. If alcoholics and drug abusers suffer from a disease and are now recovering, then they can educate others about the disease and even about how young people should live and behave. If, on the other hand, we think of them as people who are themselves poor at managing and understanding themselves, then it is indeed stupid for the rest of us, who have not been seriously addicted, to ask them for advice and information. One reviewer of former football star Bob Hayes’s book, *Run, Bullet, Run*, pointed out that, like so

many of these tracts, “Aside from a brief closing statement on personal responsibility, he self-servingly portrays himself as a victim throughout the book.”[22]

Alcoholics and addicts like Hayes regularly come into schools to relay their tortured drinking experiences and to reiterate that alcohol is a dangerous drug. But nearly every child in these schools *will* drink—just as nearly all will gamble at some point. It is as though the schools wished to undermine children’s sense of self-control and to attack their chances of becoming normal drinkers or card players, which in most cases their “nonexpert” parents are. In treatment itself, “recovering” addicts and alcoholics counsel the drug or alcohol abuser—who usually has not drunk as destructively and hurt himself or herself as much as the counselors! In all types of twelve-step groups, the most severely debilitated person tends to become the leader and model for others, so that the most out-of-control shopping addict tells others about the nature of *their* problems. Who should be counseling whom? In the case of drug abuse, a number of reviews have found that informational and scare lectures by recovering addicts produce the worst results of all prevention programs. These programs have never yet been found to reduce drug use; on the contrary, several studies have found *increased* drug use in their aftermath.[23]

It ignores the rest of the person’s problems in favor of blaming them all on the addiction.

When someone like Carrie Hamilton lectures about her youthful drug abuse and delinquency (Ms. Hamilton, unfortunately, died at a young age, long predeceasing her mother, Carol Burnett), she makes drug abuse and family failures sound like mysterious, unavoidable illnesses that some people and their families “have.” Of course, this excuses her and her mother from dealing with painful problems they would prefer to avoid. But by adopting the disease identity as her protection through the rest of her life, the youthful convert guarantees that she cannot grow beyond the limitations of her adolescent family life. Shouldn’t people hope for more than this? But they can and they often do when left to their own devices (think of Drew Barrymore, who left her whole addict identity behind her to become a star).

When treatment views addicts as being victims of a different body chemistry that *forces* them to become addicts, the treatment process ignores the person’s life problems and the functions the addiction serves for them—which is much of what the Life Process Program focuses on. For example, in family therapy where the alcoholic’s drinking is addressed as simply the result of a disease, the therapist and the family are not able to understand that some people use alcohol to air feelings they cannot express when sober. Ignoring dynamics like these leaves the drinker unable to cope with the things that led him or her to need to drink—such as doubts about self-worth, a difficult relationship with a spouse, roles (such as homosexuality) that create conflict for the person, and so on. *If labeling their addiction a disease provides people with welcome relief from the shame they feel, it also prevents them from confronting the emotional tasks they need to accomplish to attain personal wholeness.*

It traps people in a world inhabited by fellow disease-sufferers.

Many “recovering” people report that they feel comfortable only with others in exactly the same plight. They find they can’t create intimacy outside of treatment and that they are driven constantly to talk about their addiction. This is a frequent hang-up for people who attend AA/GA

meetings so religiously that they can't maintain a life outside of the group. The phenomenon of compulsive therapy attendance has made many people ask us, "Is there such a thing as addiction to treatment?" Indeed there is, when people rely on a twelve-step group or therapy to the point where it disables them from conducting outside relationships and activities.

I have often treated twelve-step members or treatment graduates who now fear they can't deal with normal society. One man, who was regularly asked to head his local AA group, had dated a series of women he met at AA. Unfortunately, all of these relationships had ended in bitterness and mutual recriminations. But when he tried to date outside the group, he discovered that non-twelve-step women found him overbearing and compulsive. "I don't want to be limited for the rest of my life to dealing with other addicts—I'd like to think I can advance beyond that," he told me.

From the women's side, of course, such stories can be terribly exploitive. Women have formed their own groups (like Women for Sobriety) for just these reasons, and a number of women report very bad experiences indeed from their time in AA or other groups, where men used the groups to create dominant relationships with women to their own advantage—emotionally, sexually, financially.

It excludes other approaches that may be more successful.

Even if one accepts that many twelve-step members are happy and successful, it is simply absurd to discourage people from trying to recover without them. We refer throughout our program to large national studies conducted by the United States Government called by their abbreviations NLAES and NESARC. These studies each tracked 40-45,000 Americans and asked them about their lifetime histories of alcohol abuse and alcoholism. The research finds decisively that most people who encounter drinking problems, even severe dependence problems, never enter treatment (only about 12 percent do), that three quarters fully recover anyhow, and even half of those don't end up abstaining! Somehow, since these people aren't at the Betty Ford Center or attending AA groups, we have to work harder to hear their independent stories.

Meanwhile, greater numbers of Americans are encouraged, even forced, to enter treatment programs and AA as a result of court orders, Employee Assistance Programs, school and university counseling programs, and expanding insurance coverage for private treatment. *Despite the almost universal belief that compelling people to attend standard treatment programs is helpful, these programs regularly demonstrate they are no more effective than self-initiated programs for curing addictions.* Psychologists William Miller and Reid Hester, reviewing all the comparative studies on treatment for alcoholism, made a surprising finding: "virtually all of them [the standard treatments] lacked adequate scientific evidence of effectiveness." At the same time, they discovered, the "treatment approaches most clearly supported as effective . . . were very rarely used in American treatment programs."^[25] What don't really work in the long run are the conversion-experience type treatments; what do work are therapies that teach people skills at self-management and coping.

Nonetheless, most American treatment personnel seem hell-bent on eliminating any other treatment for alcoholism besides twelve-step programs. In the United States, discredited disease-

treatment programs—ones that NIAAA Director Enoch Gordis believes may be “frequently useless and wasteful and sometimes dangerous”[26] —proliferate and spread into whole new areas of behavior. This issue is important because the United States spends more money on health care than any other country—and the percentage of our gross national product that we spend on health care is growing *faster* than that in any other country. The fastest-growing component of the health-care system is substance abuse and related mental-health treatments. Parity legislation dictating that insurance coverage for these kinds of treatment must rise to the level of treatment for more traditional disease treatment is a humane idea. But it will end up meaning a lot more people entering hospital programs to follow the twelve steps.

This is one reason so many companies are being forced to cut insurance benefits or are asking employees to pay a greater share. What if your insurance rates were raised to pay for a fellow employee who was undergoing a repeat treatment for cocaine addiction, since he had relapsed one or more times? How would you feel about sharing the bill for a colleague who entered an expensive hospital clinic to quit gambling or smoking, perhaps while taking a leave from work, with pay, while they concentrate on quitting? And, especially, how would you react if you had quit smoking or gambling on your own? It is morally and economically necessary for us to evaluate the effectiveness of alcoholism and other addiction treatments. For we are wasting limited health-care resources to place people in expensive treatments—treatments that have not shown they do more than inexpensive, straightforward skills counseling or than people accomplish on their own—often more reliably!

Kitty Dukakis, Joan Kennedy, Mary Kennedy and the “Disease” of Political Wives

The wife of losing presidential candidate Michael Dukakis, Kitty Dukakis, became the emblem of the addicted person of the 1990s. Kitty Dukakis emblazoned the “disease” and “chemically dependent” labels on herself. Her autobiography, *Now You Know*, trumpeted as its opening line, “I’m Kitty Dukakis and I’m a drug addict and an alcoholic.” Mrs. Dukakis seemingly was either addicted or in treatment throughout her adult life. Shortly before she joined her husband in his 1988 presidential campaign, she revealed that she had been treated for a twenty-six-year reliance on diet pills, which she began before she married Michael Dukakis. Soon after her husband’s defeat in the election, she began to drink herself unconscious and underwent a series of treatments for her alcoholism and for a variety of emotional problems.

That treatment did not succeed. Oddly, Mrs. Dukakis only began getting drunk after the election, for which she first entered the Edgehill Newport hospital. But soon after this treatment experience, she began having explosive relapses in which she drank rubbing alcohol, nail polish remover, hair spray, and other household products containing alcohol—the consumption of which may be lethal. Moreover, she discovered during the course of writing her book that she suffers from a different problem— bipolar disorder (which was then called manic-depressive disorder)—as a result of which she revealed in her book that she was receiving lithium treatment. Before that, Mrs. Dukakis had been using the antidepressant Prozac, but that hadn’t succeeded in helping her.

Every human being wished Kitty Dukakis could be happy, or at least feel better. Instead, she always appeared, in the book and on television, a forlorn human being. Kitty Dukakis didn’t

inspire the feeling that treatment was a very helpful thing. *Boston Globe* columnist, Ellen Goodman, a neighbor of Mrs. Dukakis's, wrote a column entitled "Do Our Drug Treatment Programs Label Patients as Losers?" Ms. Goodman wondered aloud how labeling oneself as sick and without hope is helpful. "What happens when those who wrestle with problems of self-esteem are required to wear such a label? Today, Kitty Dukakis describes herself by diagnosis. Drug addict. Alcoholic. Manic-depressive." [28] Ms. Goodman ended her column by wishing that Kitty Dukakis might see the brighter qualities that others have seen in her, and which seem entirely to have disappeared thanks to her various diagnoses and cures.

It is rare today to see people like Ellen Goodman who are allowed to think that our treatment doesn't seem to produce many happy, healthy people—that, indeed, we seem to be falling further behind in this effort. For Kitty Dukakis, excessive drinking was only one of many problems, ones that medical treatment seemed unable to get to the bottom of. Labeling Kitty Dukakis an alcoholic, addict, and bipolar who needed medical treatment was a way to deal with her uncomfortable marital and personal problems, but not a solution for them. Among other issues, reviewers commented about how insensitive and unaware of her problems Michael Dukakis appeared to be while his wife endured her misery. Yet Kitty Dukakis never reflected in her book on the limitations of her marriage or how to improve it. She seemingly couldn't come to grips with what was wrong with that part of her life.

Kitty Dukakis (who, thankfully I think for herself as well as the public, finally withdrew into her private life) seemed to resemble other political wives, including Joan Kennedy, the first wife of Ted Kennedy. Of course, Ted Kennedy had been famous for running around on his wife. After being in and out of treatment for alcoholism during and after that marriage, Mrs. Kennedy's children finally, in 2005, when she was 68, took legal guardianship of her affairs after several late-life drunken episodes. We don't mean to reflect on Mrs. Kennedy's fate as proving anything about the nature of addiction. But, once again, it shows that even people with access to the very best in repeated medical treatments can't find in them the solution of addiction and other life problems.

So, you might think, we surely have advanced beyond Kitty Dukakis and Joan Kennedy in dealing with the horrors of substance abuse and emotional problems. Simply limiting ourselves to well-known Democrats, however, we found in 2012 that not much has changed when the wife of Robert F. Kennedy, Jr., Mary Kennedy, killed herself. RFK Jr. is the son of President Kennedy's brother, and a prominent environmental activist. He and Mary had filed divorce papers in 2010, and Mary was seemingly in despair. She had been arrested twice after their separation for driving while intoxicated, once due to alcohol, the other time due to medication. In the unfortunate aftermath to her death, her estranged husband and her family argued over the cause of this despair, which RFK Jr. claimed was a long-term depression. But we know that Mary Kennedy had access to the best medical treatment available. And, her obituary revealed, she had been attending AA for six months.

Those who look to the lives of these prominent, but unfortunate, women for answers will likely be fed the same self-defeating solutions. To call Kitty Dukakis's, Joan Kennedy's, and Mary Kennedy's life problems diseases is to evade reality, much as these women often used medications and alcohol to do. Whether the pain they and others feel is temporary or persistent,

relatively mild or relatively severe, it did not need to rule the rest of their lives. All of these women, like the rest of us, are more than our misery and problems. What troubles people like them and addicted people reading this are life problems, not diseases. And when we have reduced them to life size, we can begin to deal with them reasonably and hopefully.

The Experience of Addiction

The question is: “If addiction isn’t a disease, then what is it?” An addiction is a habitual response and a source of gratification or security. It is a way of coping with internal feelings and external pressures that provides the addict with predictable gratifications, but that has concomitant costs. Eventually these costs may outweigh the subjective benefits the addiction offers the individual. Nonetheless, people continue their addictions as long as they believe the addictions continue to do something for them. It is important to place addictive habits in their proper context, as part of people’s lives, their personalities, their relationships, their environments, their perspectives. The effort to change an addiction will generally affect all these other facets of a person’s life as well. An addiction may involve *any* attachment or sensation that grows to such proportions that it damages a person’s life. Addictions, no matter to what, follow certain common patterns. We first made clear in *Love and Addiction* that addiction—the single-minded grasping of a magic-seeming object or involvement; the loss of control, perspective, and priorities—is not limited to drug and alcohol addictions. When a person becomes addicted, it is not to a chemical but to an experience. Anything that a person finds sufficiently consuming and that seems to remedy deficiencies in the person’s life can serve as an addiction. The addictive potential of a substance or other involvement lies primarily in the meaning it has for a person.

A person is vulnerable to addiction when that person feels a lack of satisfaction in life, an absence of intimacy or strong connections to other people, a lack of self-confidence or compelling interests, or a loss of hope. Periods such as adolescence, military service, and times of isolation or grief may for a time make people especially susceptible to an addiction. Under some circumstances, a harmful involvement can become so important to a person that addiction is very likely, as heroin addiction was for many in Vietnam. Situations in which people are deprived of family and the usual community supports; where they are denied rewarding or constructive activities; where they are afraid, uncomfortable, and under stress; and *where they are out of control of their lives*—these are situations especially likely to create addiction. The relationship between hopelessness, lack of opportunity, and persistent addiction is, of course, a template for lives in America’s ghettos. Recognizing the connection between these situational factors and addiction will explain why our wars on drugs, including the latest, never succeed. The “hook” of the addiction—the thing that keeps people coming back to it—is that it gives people feelings and gratifying sensations that they are not able to get in other ways. It may block out sensations of pain, uncertainty, or discomfort. It may create powerfully distracting sensations that focus and absorb attention. It may enable a person to forget, or feel “okay” about, insurmountable problems. It may provide artificial, temporary feelings of security or calm, of self-worth or accomplishment, of power or control, of intimacy or belonging. These benefits explain *why* a person keeps coming back to the addictive experience—an addiction accomplishes something for that person, or the person *anticipates* that it will do so, however illusory these benefits may actually be.

Addiction, drug abuse, alcoholism, obesity, gambling, and smoking all involve and are fueled by value choices. Think of people whose lives are “together”—who enjoy strong emotional bonds with others, productive work, satisfying feelings of competence and of fun, and a sense of responsibility toward others. Will they become addicted to drugs or alcohol because of some physiological susceptibility and allow the addiction to undo the fabric of their lives? For you personally, can you imagine getting so drunk that you would abuse your infant child? It just doesn’t happen that way. What would it take for you to lose your home through a gambling addiction and leave that child homeless? If you have better things to do and value other things more than escape into intoxication, then you won’t make intoxication the center of your life. And if you are addicted, you can best overcome it by creating or re-creating those personal strengths and values.

Whatever the subjective benefits of an addiction or the values that drive an addiction, the person pays a price for an addictive involvement. Addictions make people less aware of and less able to respond to other people, events, and activities. Thus, the addictive experience reinforces and exacerbates the problems the person wanted so badly to get away from in the first place. In the person’s inner, subjective experience, the addiction may make things seem better. But in the real world, it only makes things worse. With the worst addictions, jobs and relationships fall away; health deteriorates; debts increase; opportunities disappear; the business of life is neglected. The person is increasingly “out of touch” with nourishing contacts and essential responsibilities. This growing alienation from the realities of life sets the person up for the trauma of withdrawal. When the addictive experience is removed, the person is deprived of what has become his or her primary source of comfort and reassurance. Simultaneously, the person “crash-lands” back onto an alien world, a world from which the person has been using the addiction to escape. Compared with these existential torments, the purely physical dislocations of withdrawal are, even for most heroin addicts, not particularly debilitating. After all, nearly everyone who receives powerful narcotics in the hospital gives them up after returning home or when the illness is over. Consider also that drug addicts and alcoholics indicate that the most unbearable drug withdrawal is from cigarettes. And if one puts all withdrawal on a scale, probably the worst of all occurs in the case of failed love relationships.

The experience of withdrawal, like that of addiction, is shaped by the way a person interprets it. In therapeutic communities like Daytop Village in New York, addicts are not excused from their normal duties when they undergo withdrawal; as a result, withdrawing addicts—even those who have had several withdrawal episodes previously—continue mopping floors and carrying out other duties. Cultural beliefs also play a crucial role in addiction—for example, beliefs that are widely propagated about the power of a drug to enslave a person and the difficulty of escaping it actually *contribute* to the difficulties of withdrawal. Equally important are the person’s readiness to confront withdrawal and belief that he or she can manage it. If you are convinced that withdrawal will be intolerably painful and that you cannot withstand it, or if you don’t have sufficiently powerful reasons to confront withdrawal experiences, you won’t be prepared to withdraw from your addiction. The addict who feels incapable of existing without a drug or any addictive experience doesn’t even want to try.

Ironically, one of the beliefs that most contribute to the susceptibility to addiction is *the belief in the power of addiction itself*. Believing that drugs or an addiction are stronger than you are means

you will become addicted more easily and stay addicted longer. But if you recognize that drugs and alcohol and smoking and other addictions *never* take away your own responsibilities and capacity to control your destiny—even if you have alcoholic relatives or have had addictive problems in the past—you always stand a better chance of avoiding addiction or dealing with it successfully.

A Commonsense Way of Thinking About Overcoming an Addiction

Although the schematic description above is useful for understanding what addiction is and how it comes about, we need not think of all our troublesome habits or fixations in such dire terms. In fact, when we overdramatize our addictions, we may do ourselves an injustice and make change more difficult. An addiction may be more or less severe—and a person may be more or less able to give it up—depending on the circumstances of the person's life. Addiction is more likely in stressful times, times when gratifications are slim, times when a person is less together or secure. Likewise, one type of excess may be more stubbornly entrenched in a person's routine, or more closely linked to a person's self-doubt and insecurity, than another.

Addiction occurs along a continuum—there is no easy test to tell you whether you have an addiction or just a bad habit. For example, half of all Americans are overweight. Are they all addicted overeaters? Many people encounter significant health risks because of the way they eat (recall that heart disease is America's major killer). Are these the addicts? Some people are preoccupied day and night with their eating; they are suffused with guilt over eating too much, yet they are unable to change their eating habits. Surely, these are the addicts, we think. Some of these people encounter serious—even life-threatening—problems, but continue to overeat. At the furthest extreme of addiction are the minuscule number of people who become so fat they are completely immobile—people we sometimes see on television who may not even be able to fit through their doorways. If we call only these people—people who have given up all effort to control their eating—true addicts, we end up with a fraction of a percentage of addicted overeaters, and books wouldn't need to be written for millions of people who fear they have food addictions. Moreover, for this minuscule group, concepts such as “denial” hardly seem to have meaning—does the twelve-hundred-pound man who hasn't left his house in years really need to be told that he has an addictive eating problem?

For most people, the exercise of drawing the line that divides “addicted” from “normal” is not very helpful. We need to remember that nearly all people cut back and forth across these categories at different points in their lives and in different situations. Although letting your urges overcome you to gain total control of your life is a relatively rare phenomenon, everyone has addictive urges and sometimes gives in to them. Addiction characterizes some aspect of everyone's life—this is one reason why it is so ridiculous to think of it as a disease. Thin people whom we envy for their self-control will tell us there are some treats they can't keep in the house because otherwise they would eat them all at once. Remember that people whom we admire for having had the strength to quit smoking used to search ashtrays desperately looking for a butt when they ran out of cigarettes!

What we most need to know is not how bad off or how genuinely addicted we are but, rather, how people learn to resist successfully the addictive or unhealthy urges that come with being

human. How do they construct full lives, develop alternatives to addiction, learn the strength to stop after having started or, when necessary, not to start at all? And that's what we aim to do with you in the Life Process Program, now that you have read all about addiction.

So let's get started, shall we?

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20. Richard Weedman, quoted in M. Worden, "Adolescent Treatment on the Hot Seat," *U. S. Journal of Drug and Alcohol Dependence*, June 1985, p. 14.
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22. R. Regan, "In Short/Football," *New York Times Book Review*, October 7, 1990, p. 18.
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24. This organization has been known as the National Council on Alcoholism (NCA) for most of its life. The NCA began as the National Committee for Education on Alcoholism in 1944, but changed its name in the early 1950s. The NCA's primary focus has always been alcoholism. However, in 1990, in order to gain greater credibility in the addiction field, the NCA renamed itself the National Council on Alcoholism and Drug Dependence (NCADD). See B. H. Johnson, "The Alcoholism Movement in America: A Study in Cultural Innovation," doctoral dissertation, University of Illinois at Urbana-Champaign, 1973; M. E. Lender and J. K. Martin, *Drinking in America: A History* (New York: Free Press, 1982).
25. Miller and Hester, "Effectiveness of Alcoholism Treatment," p. 122.
26. Gordis, "Accessible and Affordable Health Care," p. 582.
27. "Inpatient Psych Rates Zoom," *Health Care Competition Week*, 24, 1989, p. 2.
28. E. Goodman, "Do Our Drug Treatment Programs Label Patients as Losers?" *Boston Globe* syndicated column, September 19, 1990.