22

Drugs and Free Will

Jeffrey A. Schaler

"That was the disease talking . . . I was a victim." So declared Marion Barry, fifty-four, mayor of the District of Columbia. Drug addiction is the disease. Fourteen charges were lodged against him by the U.S. attorney's office, including three counts of perjury, a felony offense for lying about drug use before a grand jury; ten counts of cocaine possession, a misdemeanor; and one count of conspiracy to possess cocaine.

Barry considered legal but settled for moral sanctuary in what has come to be known as the disease-model defense. He maintained that he "was addicted to alcohol and had a chemical dependency on Valium and Xanax." These are diseases, he asserted, "similar to cancer, heart disease and diabetes." The implication: It is as unfair to hold him responsible for drug-related criminal behavior as it is to hold a diabetic responsible for diabetes.

The suggestion was that his disease of addiction forced him to use drugs, which in turn eroded his volition and judgment. He did not voluntarily break the law. According to Barry, "the best defense to a lie is truth," and the truth, he contended, is that he was powerless in relation to drugs, his life unmanageable and "out of control." His behaviors or acts were purportedly the result, that is, symptomatic, of his disease. And jail, say those who agree with him, is not the answer to the "product of an illness."

This disease alibi has become a popular defense. Baseball's Pete Rose broke through his "denial" to admit he has a "gambling disease." Football's Dexter Manley claimed his drug use was caused by addiction disease. Addiction treatment professionals diagnosed televangelist Jimmy Swaggart as

having "lost control" of his behavior and as being "addicted to the chemical released in his brain from orgasm." They assert that Barry, Rose, Manley, and Swaggart all need "twelve-step treatment" for addiction, the putative disease that, claims the multimillion-dollar addiction treatment industry, is reaching epidemic proportions and requires medical treatment. To view addiction-related behaviors as a function of free will, they often say, is cruel, stigmatizing, and moralistic, an indication that one does not really understand the disease.

Others are more reluctant to swallow the disease model. After testing positive for cocaine in 1987, Mets pitcher Dwight Gooden said he could moderate his use of the drug and was not addicted. This is heresy according to disease-model proponents, a sign of denial, the salient symptom of the disease of addiction and considered by some to be a disease itself. There is no such thing as responsible drug taking or controlled drinking for an addict or an alcoholic, they assert.

The tendency to view unusual or questionable behavior as part of a disease process is now being extended, along with the characteristic theory of "loss of control," to include all sorts of "addictive" behaviors. We are currently experiencing the "diseasing of America," as social-clinical psychologist Stanton Peele describes it in his recent book of the same name (1989). The disease model is being applied to any socially unacceptable behavior as a means of absolving people of responsibility for their actions, criminal or otherwise. The practice is justified on this basis: Drug use constitutes an addiction. Addiction is a disease. Acts stemming from the disease are called symptoms. Since the symptoms of a disease are involuntary, the symptoms of drug addiction disease are likewise involuntary. Addicts are thus not responsible for their actions.

Is this analogizing of drug addiction to real diseases like diabetes, heart disease, and cancer scientifically valid? Or is the word "disease" simply a misused metaphor? Does drug use truly equal addiction? Are the symptoms of drug addiction really involuntary?

Loss of Control

At the heart of the idea that drug use equals addiction is a theory known as "loss of control." This theory may have originated among members of Alcoholics Anonymous "to denote," as described by researcher E. M. Jellinek in his book *The Disease Concept of Alcoholism* (1960), "that stage in the development of [alcoholics'] drinking history when the ingestion of one alcoholic drink sets up a chain reaction so that they are unable to adhere to their intention to 'have one or two drinks only' but continue to ingest more and more—often with quite some difficulty and disgust—contrary to their volition."

Loss of control also suggests that addictive drugs can start a biochemical

chain reaction experienced by an addict as an uncontrollable physical demand for more drugs. Drug addicts are people who have allegedly lost their ability to control their ingestion of drugs.

In a speech in San Diego [in 1989, former] National Drug Policy Director William Bennett explained that a drug "addict is a man or woman whose power to exercise . . . rational volition has . . . been seriously eroded by drugs, and whose life is instead organized largely—even exclusively—around the pursuit and satisfaction of his addiction."

Yet, there is a contradiction in Bennett's point of view. If an addict's power to exercise rational volition is seriously eroded, on what basis does the addict organize life "largely even exclusively around the pursuit and satisfaction of his addiction"? An act of organizing is clearly a volitional act, an act of will.

Three Models of Drug Use

Etiological paradigms for understanding drug use can be distilled into three models. Aside from the disease model, there are two other ways of looking at drug addiction: the free-will model and the moralistic model. In the free-will model drug use is envisioned as a means of coping with environmental experience, a behavioral choice and a function of psychological and environmental factors combined. The nervous system of the body is conceived of as a lens, modulating experience as self and environment interact. The self is like the film in a camera, where experience is organized and meaning is created. The self is not the brain.

Individual physiological differences affect the experience of self. They do not create it. The quality of a camera lens affects the image of the environment transposed to the film. When the image is unpleasant, drugs are used to modify the lens.

The self is the executor of experience in this model, not the nervous system. Drug use may or may not be an effective means of lens modification. The assessment of drug effectiveness and the price of drug use are viewed as moral, not medical, judgments.

The recommended therapy for the drug user is: (1) a matter of choice; (2) concerned with awareness and responsibility; (3) a process of values clarification; (4) a means of support to achieve specific behavior goals; and (5) an educational process that involves the learning of coping strategies.

The moralistic model harkens back to the days of the temperance movement and is often erroneously equated with the free-will model. Here, addiction is considered to be the result of low moral standards, bad character, and weak will. Treatment consists of punishment for drug-using behavior. The punitive nature of America's current war on drugs with its call for "user accountability" is typical of the moralistic perspective.

Addicts are viewed as bad people who need to be rehabilitated in "boot camps." They are said to be lacking in values. President Bush gave a clear example of this during the televised debates of the 1988 presidential campaign. When asked how to solve the drug problem, he answered, "by instilling values."

The drug user's loss of values is often attributed to the presence of a disease. A "plague" and "epidemic" of drug use are said to be spreading across the land. Since users are sick and supposedly unaware of their disease, many people feel justified in coercing them into treatment, treatment that is primarily religious in nature. Thus, the moralistic model is paternalistic.

In the disease or medical model, addicts are considered to have physiological differences from normal people, differences based in a genetic source or created through the chemical effects of drugs. Instead of focusing on the interaction between the self and the environment, advocates of the disease model view the interaction between physiology and the chemicals in drugs as both the disease and the executor of behavior and experience. In this sense the model is mechanistic. The person is viewed as a machine, a highly complex machine, but a machine nevertheless. The disease of addiction is considered to be incurable. People in treatment can only reach a state of perpetual recovery. Treatment of symptoms involves admitting that one is ill by breaking through denial of the disease and turning over one's life to a "higher power" in a spiritual sense and psychological support to achieve sobriety. Addicts are not bad but sick people. Intervention is required because the machine has broken. Thus, the disease model is both paternalistic and mechanistic.

Addiction Redefined

Proponents of the will and the disease models disagree with the moralistic perspective, but for different reasons. The former believe addicts should not be punished for having unconventional values. They believe treatment should focus on changing the psychological and environmental conditions conducive to drug use. Coping skills should be taught along with the building of self-esteem and self-efficacy. The latter believe that addicts should not be punished for being sick and that treatment should focus on the biological factors that cause and reinforce drug use.

James R. Milam and Katherine Ketcham, authors of *Under the Influence* (1983), are popular spokespersons for the disease-model camp. They argue that alcoholics should not be held accountable for their actions because these are the "outpourings of a sick brain. . . . They are sick, unable to think rationally, and incapable of giving up alcohol by themselves."

Similarly, physician Mark S. Gold, an expert on cocaine use and treatment, says in his book *800-COCAINE* (1985) that cocaine should not be

regarded as a benign recreational drug because it can cause addiction. As with alcoholism, says Gold, there is no cure for cocaine addiction except permanent and total abstention from its use. Cocaine produces "an irresistible compulsion to use the drug at increasing doses and frequency in the face of serious physical and/or psychological side effects and the extreme disruption of the user's personal relationships and system of values." According to Gold "if you feel addicted, you are addicted." Addiction, be it to alcohol or cocaine, is, as far as Milam, Ketcham, and Gold are concerned, identical to loss of control. The drug itself and physiological changes in the addict's body are said to control further ingestion of drugs in what is viewed as an involuntary process.

It may be helpful to look at how the term "addiction" has developed. Its use in conjunction with drugs, disease, loss of control, withdrawal, and tolerance developed out of the moralistic rhetoric of the temperance and anti-opium movements of the nineteenth century, not through scientific inquiry. Such a restrictive use of the word served multiple purposes according to psychologist Bruce Alexander of Simon Fraser University in British Columbia, lead author of an article on the subject. Linking addiction to drugs and illness suggested it was a medical problem. It also helped to scare people away from drug use, a tactic that became increasingly important with anti-opium reformers. Etymologically, the word "addiction" comes from the Latin "*dicere*" (infinitive form) and, combined with the preposition "*ad,*" means "to say yes to," "consent." Consent implies voluntary acceptance.

The idea of choice, volition, or voluntariness inherent in the meaning of the word "addiction" is significant to will-model proponents because the concept of addiction as a disease depends so much on the loss-of-control theory. Most people think of addiction with the element of volition decidedly absent. Studies of alcoholics and cocaine and heroin addicts conducted over the past twenty-six years appear to refute this claim, however.

The Myth of Loss of Control

In 1962 British physician and alcohol researcher D. L. Davies rocked the alcoholism field by publishing the results of a long-term followup study of patients treated for alcoholism at the Maudsley Hospital in London. Abstinence, long considered the only cure for alcoholism, was seriously questioned as the only form of treatment when seven out of ninety-three male alcoholics studied exhibited a pattern of normal drinking. Physiological differences purportedly present in alcoholics did not seem to affect their ability to control drinking.

Four years later, *The Lancet* published an important study by British psychiatrist Julius Merry that supported Davies's findings. Alcoholics who were

unaware they were drinking alcohol did not develop an uncontrollable desire to drink more, undermining the assertion by supporters of the disease model that a small amount of alcohol triggers uncontrollable craving. If alcoholics truly experience loss of control, then the subjects of the study should have reported higher craving whether they believed their beverages contained alcohol or not.

According to the loss-of-control theory, those with the disease of alcoholism cannot plan their drinking especially when going through a period of excessive craving. Yet, psychologist Nancy Mello and physician Jack Mendelson, leading alcoholism researchers and editors of the *Journal of Studies on Alcohol,* reported in 1972 that [they] found alcoholics bought and stockpiled alcohol to be able to get as drunk as they wanted even while undergoing withdrawal from previous binges. In other words, they could control their drinking for psychological reasons; their drinking behavior was not determined by a physiologically uncontrollable force, sparked by use of alcohol.

As Mello and Mendelson wrote in summary of their study of twenty-three alcoholics published in *Psychosomatic Medicine*: "It is important to emphasize that even in the unrestricted alcohol-access situation, no subject drank all the alcohol available or tried to 'drink to oblivion.' These data are inconsistent with predictions from the craving hypothesis so often invoked to account for an alcoholic's perpetuation of drinking. No empirical support has been provided for the notion of craving by directly observing alcoholic subjects in a situation where they can choose to drink alcohol in any volume at any time by working at a simple task. There has been no confirmation of the notion that once drinking starts, it proceeds autonomously."

A significant experiment conducted by Alan Marlatt of the University of Washington in Seattle and his colleagues in 1973 supported these findings by showing that alcoholics' drinking is correlated with their beliefs about alcohol and drinking. Marlatt successfully disguised beverages containing and not containing alcohol among a randomly assigned group of sixty-four alcoholic and social drinkers (the control group) asked to participate in a "taste-rating task." One group of subjects was given a beverage with alcohol but was told that although it tasted like alcohol it actually contained none. Subjects in another group were given a beverage with no alcohol (tonic) but were told that it did contain alcohol.

As Marlatt and co-authors reported in the *Journal of Abnormal Psychology,* they found "the consumption rates were higher in those conditions in which subjects were led to believe that they would consume alcohol, regardless of the actual beverage administered." The finding was obtained among both alcoholic and social drinker subjects. Marlatt's experiment suggests that according to their findings the ability of alcoholics to stop drinking alcohol is not determined by a physiological reaction to alcohol. A psychological fact—the belief that they were drinking alcohol—was operationally significant, not alcohol itself.

Similar findings have been reported in studies of cocaine addiction. Patricia G. Erickson and her colleagues at the Addiction Research Foundation in Ontario concluded, in their book *The Steel Drug* (1987), after reviewing many studies on cocaine that most social-recreational users are able to maintain a low-to-moderate use pattern without escalating to dependency and that users can essentially "treat themselves." They state, "Many users particularly appreciated that they could benefit from the various appealing effects of cocaine without a feeling of loss of control."

Erickson and co-authors cite in support a study by Spotts and Shontz (1980) that provides "the most in-depth profile of intravenous cocaine users to date." They state: "Most users felt a powerful attachment to cocaine, but not to the extent of absolute necessity. [A]ll agreed that cocaine is not physically addicting . . . [and] many reported temporary tolerance."

In a study by Siegel (1984) of 118 users, 99 of whom were social-recreational users, described by Erickson et al. as the only longitudinal study of cocaine users in North America, "all users reported episodes of cocaine abstinence."

These results thus further support the hypothesis that drug use is a function of psychological, not physiological, variables. Even the use of heroin, long considered "the hardest drug," can be controlled for psychological and environmental reasons that are important to heroin addicts. A notable study of 943 randomly selected Vietnam veterans, 495 of whom "represented a 'drug-positive' sample whose urine samples had been positive for opiates at the time of departure" from Vietnam, was commissioned by the U.S. Department of Defense and led by epidemiologist Lee N. Robins. The study shows that only 14 percent of those who used heroin in Vietnam became readdicted after returning to the United States. Her findings, reported in 1975, support the theory that drug use is a function of environmental stress, which in this example ceased when the veterans left Vietnam. Veterans said they used heroin to cope with the harrowing experience of war. As Robins and coauthors wrote in *Archives of General Psychiatry*:

> . . . [I]t does seem clear that the opiates are not so addictive that use is necessarily followed by addiction nor that once addicted, an individual is necessarily addicted permanently. At least in certain circumstances, individuals can use narcotics regularly and even become addicted to them but yet be able to avoid use in other social circumstances. . . . How generalizable these results are is currently unknown. No previous study has had so large and so unbiased a sample of heroin users.

The cocaine and heroin studies are important for several reasons. They challenge the contention that drug addiction is primarily characterized by loss of control. Moreover, these and similar studies support the idea that what goes on outside of a person's body is more significant in understanding drug use, including alcoholism, than what goes on inside the body.

Consider for a moment how a person enters and exits drug use. While disease-model proponents such as Milam, Ketcham, and Gold claim that abstinence is the only cure for this "special disease," implying that strength of will is irrelevant, we must recognize drug use, and abstinence from it, for what they really are —volitional acts.

Addiction and the Law

This is a markedly different process from that in real diseases. A person cannot will the onset of cancer, diabetes, or epilepsy. Nor can these diseases be willed away. While people may exercise responsibility in relation to their diseases, they cannot be held responsible for actually creating them. Research supports the idea that drug use does not automatically lead to loss of control—a drug-ingestion frenzy devoid of any volitional component. Unfortunately, viewing addiction as a disease has often led to attempts to absolve drug users of their responsibility for criminal actions.

The extent of an addict's responsibility for criminal behavior has been debated in the courts for more than twenty-five years. . . . In *Traynor* v. *Turnage* (1988), the Supreme Court upheld the right of the Veterans Administration (VA) to define alcoholism to be the result of willful misconduct. The petitioner in this case asserted he was unable to claim VA education benefits because he was an alcoholic; he further claimed that he suffered from a disease called alcoholism and that the law prohibits discrimination on the basis of a disease. The VA called his alcoholism "willful misconduct." Soon thereafter, however, Congress passed a law for veterans that expressly forbids considering the disabling effects of chronic alcoholism to be the result of willful misconduct. However, this law does not define alcoholism as a disease, nor does it prohibit drug addiction from being regarded as "willful misconduct."

According to Herbert Fingarette, a professor of philosophy at the University of California in Santa Barbara and an expert on addiction and criminal responsibility, much of the controversy arising from Traynor and similar cases—such as *Powell* v. *Texas* (1968), a case involving the disease-model defense of a man convicted for public intoxication—stemmed from a Supreme Court ruling in *Robinson* v. *California* (1962).

In this case the Court decided that narcotics addiction is a disease and held that criminal punishment of a person thus afflicted violates the Eighth Amendment's prohibition against cruel and unusual punishment. As Justice William O. Douglas concurred, "The addict is a sick person." But the Court ruled only insofar as Robinson's status as a drug addict was concerned. Its decision had nothing to do with any acts stemming from that status.

In *Powell* the Court held against the use of status as an alcoholic as exculpatory. Powell, an alcoholic, was held to be responsible for his criminal

actions. In *Traynor,* the Court upheld the decision made in *Powell.* Traynor and Powell were not absolved of responsibility for their actions because of their alcoholism disease. Robinson, however, was absolved of criminal responsibility because of his status as a drug addict. In *Robinson,* the Court equated punishment for the status of narcotics addiction with punishment for disease affliction. From this viewpoint, an addict's acts are considered to be inseparable from his status as an addict because they are a symptom of the disease and thus an involuntary result of status.

The critical point here is the inseparability of status and act. Certain acts are considered to be part of disease status. Disease is involuntary. Therefore, acts stemming from the disease are exculpable. Are the acts that stem from status really involuntary? This belief is the legal corollary to Jellinek's notion of loss of control.

Disease vs. Behavior

According to professor of psychiatry Thomas Szasz at the State University of New York in Syracuse, a disease, as textbooks on pathology state, is a phenomenon limited to the body. It has no relationship to a behavior such as drug addiction, except as a metaphor. Szasz argues against the disease model of addiction on the basis of the following distinction between disease and behavior. In *Insanity: The Idea and Its Consequences* (1987) he writes:

> [B]y behavior we mean the person's "mode of conducting himself" or his "deportment" . . . the name we attach to a living being's conduct in the daily pursuit of life. . . . [B]odily movements that are the products of neurophysiological discharges or reflexes are not behavior. . . . The point is that behavior implies action, and action implies conduct pursued by an agent seeking to attain a goal.

The products of neurophysiological discharges or reflexes become behavior when they are organized through intent, a willful act. Drug-taking behavior is not like epilepsy. The former involves intentional, goal-seeking behavior. An epileptic convulsion is an unconscious, unorganized neurophysiological discharge or reflex, not a behavior.

In another example, smoking cigarettes and drinking alcohol are behaviors that can lead to the diseases we call cancer of the lungs and cirrhosis of the liver. Smoking and drinking are behaviors. Cancer and cirrhosis are diseases. Smoking and drinking are not cancer and cirrhosis.

The alleged absence of voluntariness or willfulness forms the basis of legal rulings that extend beyond the minimalist interpretation of *Robinson,* exculpating criminal behavior on the basis of a person's supposed disease status. Yet because behavior such as drug use involves voluntariness it seems

an individual who uses drugs should not be absolved of responsibility for criminal behavior on the grounds that his actions are involuntary symptoms of drug addiction disease.

Many advocates of the disease model cite as further evidence for their view the results of genetic studies involving the heritability of alcoholism. Recently, the dopamine D_2 receptor gene was found to be associated with alcoholism. A study by Kenneth Blum and co-authors, published in the *Journal of the American Medical Association,* suggests that this gene confers susceptibility to at least one form of alcoholism. The goal of this and similar studies is to identify the at-risk population in order to prevent people from becoming alcoholics and drug addicts.

What such studies do not tell us is why people who are not predisposed become alcoholics and why those who are predisposed do not. It seems more than reasonable to attribute this variance to psychological factors such as will, volition, and choice, as well as to environmental variables such as economic opportunity, racism, and family settings, to name just a few. Experimental controls accounting for genetic versus environmental influences on alcoholic behavior are sorely lacking in these studies.

The basis upon which people with alleged alcoholism disease are distinguished from mere heavy drinkers is arbitrary. No reliable explanation has yet been put forth of how the biological mechanisms theoretically associated with alcoholism and other forms of drug addiction translate into drug-taking behavior. Moreover, Annabel M. Bolos and co-authors, in a rigorous attempt to replicate the Blum findings, reported higher frequencies of the D_2 receptor gene found in their control population than in the alcoholic population in the same journal seven months later.

Treatment

Finally, the contribution of treatment to exposing the myth of addiction disease warrants mention. Since his arrest at the Vista Hotel in Washington, D.C., Marion Barry has undergone treatment for alcohol addiction and chemical dependency at the Hanley-Hazelden clinic in West Palm Beach, Florida, and at the Fenwick Hall facility near Charleston, South Carolina. Barry said he needs treatment because he has "not been spiritual enough." His plan is to turn his "entire will and life over to the care of God . . . using the twelve-step method and consulting with treatment specialists." He said he will then "become more balanced and a better person."

The twelve-step program Barry is attempting to follow is the one developed by Alcoholics Anonymous (AA), a spiritual self-help fellowship. AA is the major method dealing with alcoholism today. All good addiction treatment facilities and treatment programs aim at getting the patient into AA and

similar programs such as Narcotics Anonymous. Yet several courts throughout the United States have determined that AA is a religion and not a form of medicine, in cases involving First Amendment violations, most recently in *Maryland* v. *Norfolk* (1989). Anthropologist Paul Antze at York University in Ontario has written extensively on AA and describes the "point-by-point homology between AA's dramatic model of the alcoholic's predicament and the venerable Protestant drama of sin and salvation."

Successful treatment from this perspective is dependent upon a religious conversion experience. In addition, patients are required to adopt a disease identity. If they do not, they are said to be in denial. But such an approach is a psychologically coercive remedy for a moral problem, not a medical one. And here—in their concepts of treatment—is where the disease model and moralistic model of addiction seem to merge.

With so much evidence to refute it, why is the view of drug addiction as a disease so prevalent? Incredible as it may seem, because doctors say so. One leading alcoholism researcher asserts that alcoholism is a disease simply because people go to doctors for it. Undoubtedly, addicts seek help from doctors for two reasons. Addicts have a significant psychological investment in maintaining this view, having learned that their sobriety depends on believing they have a disease. And treatment professionals have a significant economic investment at stake. The more behaviors are diagnosed as diseases, the more they will be paid by health insurance companies for treating these diseases.

Most people say we need more treatment for drug addiction. But few people realize how ineffective treatment programs really are. Treatment professionals know this all too well. In fact, the best predictor of treatment success, says Charles Schuster, director of the National Institute on Drug Abuse, is whether the addict has a job or not.

George Vaillant, professor of psychiatry at Dartmouth Medical School, describes his first experience, using the disease model and its effectiveness in diagnosing alcoholism, in *The Natural History of Alcoholism* (1983):

> . . . I learned for the first time how to diagnose alcoholism as an illness . . . Instead of pondering the sociological and psychodynamic complexities of alcoholism. . . . [A]lcoholism became a fascinating disease. . . . [B]y inexorably moving patients into the treatment system of AA, I was working for the most exciting alcohol program in the world. . . . After initial discharge, only five patients in the Clinic sample never relapsed to alcoholic drinking, and there is compelling evidence that the results of our treatment were no better than the natural history of the disease.

This is important information because the definition of who an alcoholi or drug addict is and what constitutes treatment as well as treatment succe can affect the lives of people who choose not to use drugs as well as tho

who choose to. For example, Stanton Peele has written extensively on how studies show that most people arrested for drinking and driving are directed into treatment for alcoholism disease, yet the majority are not alcoholics. Those receiving treatment demonstrate higher recidivism rates, including accidents, driving violations, and arrests, than those who are prosecuted and receive ordinary legal sanctions.

Furthermore, in a careful review of studies on treatment success and followup studies of heroin addicts at the United States Public Health Service hospital for narcotics addicts at Lexington, Kentucky, where "tens of thousands of addicts have been treated," the late Edward M. Brecher concluded in *Licit & Illicit Drugs* (1972) that "[a]lmost all [addicts] became readdicted and reimprisoned . . . for most the process is repeated over and over again . . . [and] no cure for narcotics addiction, and no effective deterrent, was found there—or anywhere else."

Brecher explained the failure of treatment in terms of the addictive property of heroin. Vaillant suggested that tuberculosis be considered as an analogy. Treatment, he said, rests entirely on recognition of the factors contributing to the "resistance" of the patient. And here is the "catch-22" of the disease model. Addiction is a disease beyond volitional control except when it comes to treatment failure, wherein "resistance" comes into play.

Neither Brecher nor Vaillant recognized that treatment does not work because there is nothing to treat. There is no medicine and there is no disease. The notions that heroin as an addictive drug causes addicts not to be treated successfully, or that "resistance" causes alcoholics to be incurable, are mythical notions that only serve to reinforce an avoidance of the facts: Addicts and alcoholics do not "get better" because they do not want to. Their self-destructive behaviors are not disturbed. They are disturbing.

All of this is not to suggest that the people we call addicts are bad, suffering from moral weakness and lack of willpower, character, or values. Drug addicts simply have different values from the norm and often refuse to take responsibility for their actions. Public policy based on the disease model of addiction enables this avoidance to continue by sanctioning it in the name of helping people. As a result, criminals are absolved of responsibility for their actions, drug prevention and treatment programs end up decreasing feelings of personal self-worth and power instead of increasing them, and people who choose not to use drugs pay higher taxes and health insurance premiums to deal with the consequences of those who do.

Drug use is a choice, not a disease. Still, our current drug policies give the drug user only two options: treatment or jail. But if the drug user is sick, that is, is not responsible for his behavior, why should he go to jail for his illness? And if the drug user is someone who chooses to use drugs because he finds meaning in doing so, why should he be forced into treatment for having unconventional values? "Unconventional values" is not a disease.

"Treatment" for drug addiction is a misnomer. Education is a more appropriate term. In this modality a drug addict is given psychological and environmental support to achieve goals based on an identification of values and behavior-value dissonance. Behavioral accountability is stressed insofar as people learn about the consequences of their actions.

The legal arguments set forth to exculpate criminals because of addiction disease do not seem to be supported by scientific findings. Quite to the contrary, research suggests that drug addiction is far from a real disease. And as long as drug addiction can be blamed on a mythical disease, the real reasons why people use drugs—those related to socioeconomic, existential, and psychological conditions including low self-esteem, self-worth, and self-efficacy—can be ignored.

References

Alexander, B. K. (1990). *Peaceful Measures: Canada's Way Out of the "War on Drugs."* Toronto: University of Toronto Press.

Blum, K., E. P. Noble, P. J. Sherida et al. (1990). "Allelic Association of Human Dopamine D_2 Receptor Gene in Alcoholism." *Journal of the American Medical Association* 263: 2055–60.

Boles, A. M., M. Dean, S. Lucas-Derse, M. Ramsburg, G. L. Brown, and D. Goldman. (1990). "Population and Pedigree Studies Reveal a Lack of Association between the Dopamine D_2 Receptor Gene and Alcoholism." *Journal of the American Medical Association* 264: 3156–60.

Brecher, E. M., and the editors of *Consumer Reports.* (1983). *Licit and Illicit Drugs.* Boston: Little, Brown and Co.

Davies, D. L. (1985). "Normal Drinking in Recovered Alcohol Addicts." *Quarterly Journal of Studies on Alcohol* 23: 94–104.

Douglas, M. (ed.). (1987). *Constructive Drinking: Perspectives on Drink from Anthropology.* New York: Cambridge University Press.

Erickson, P. G., E. M. Adlaf, G. F. Murray, and R. G. Smart. (1987). *The Steel Drug: Cocaine in Perspective.* Lexinton, Mass.: Lexington Books.

Fingarette, H. (1988). *Heavy Drinking: The Myth of Alcoholism as a Disease.* Berkeley, Calif. University of California Press.

———. (1989). "The Perils of Powell: In search of a Factual Foundation for the Disease Concept of Alcoholism." *Drugs & Society* 7: 1–27. (Originally published in *Harvard Law Review* 83 [1970]: 793–812.)

———. (1987). *Insanity: The Idea and Its Consequences.* New York: John Wiley & Sons.

Gold, M. S. (1985). *800-Cocaine.* New York: Bantam Books, Inc.

Institute of Medicine. (1990). *Broadening the Base of Treatment for Alcohol Problems.* Washington, D.C.: National Academy Press.

Jellineck, E. M. (1960). *The Disease Concept of Alcoholism.* New Haven, Conn.: Hillhouse Press.

Marlatt, G. A., B. Deming, and J. B. Reid. (1973). "Loss-of-Control Drinking in Alcoholics: An Experimental Analogue." *Journal of Abnormal Psychology* 81: 233–41.

Mello, N. K., and J. H. Mendelson. (1972). "Drinking Patterns during Work-Contingent and Noncontingent Alcohol Acquisition." *Psychosomatic Medicine* 34: 139–64.

Merry, J. (1962). "The 'Loss-of-Control' Myth." *Lancet* 1: 1257–58.

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

Peele, S. (1989). *Diseasing of America: Addiction Treatment Out of Control.* Lexington, Mass.: Lexington Books.

Peele, S., A. Brodsky, and M. Arnold. (1991). *The Truth about Addiction and Recovery.* New York Simon and Schuster.

Robins, L. N., J. E. Helzer, and D. H. Davis. (1975). "Narcotic Use in Southeast Asia and Afterward: An Interview Study of 898 Vietnam Returnees." *Archives of General Psychiatry* 32: 955–61.

Siegel, R. K. (1984). "Cocaine and the Privileged Class: A Review of Historical and Contemporary Images." *Advances in Alcohol and Substance Abuse* 4: 37–49.

Szasz, T. S. (1985). *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers.* Holmes Beach, Fla.: Learning Publications.

Vaillant, G. (1983). *The National History of Alcoholism.* Cambridge, Mass.: Harvard University Press.