Psychiatric Times, Vol. XX, No. 2, February 2003, pp. 11 & 13.

Cf. http://www.psychiatrictimes.com/p0210pt.html and
http://www.psychiatrictimes.com/p0210ctpt.html

Reader's Forum

Addiction—Choice or Disease

Both views in the "addiction is a choice/disease" point-counterpoint (*Psychiatric Times* October 2002, p54) leave out critical aspects of addiction, without which it is not possible to make sense of the matter.

Jeffrey A. Schaler, Ph.D.'s, view that addicts choose to use seems glib in the face of those addicts like David (son of Robert) Kennedy and Terry (daughter of George) McGovern who were children of privilege who killed themselves with chronic drug/alcohol use. These are extreme cases where the substance seemingly takes over the individual's ability to choose.

However, I believe it is wrong to generalize their fates to all drug and alcohol misusers, including even quite compulsive users for whom internal and environmental cues and options continue to play critical roles. John H. Halpern, M.D., appears to make the opposite error, seriously understating the variety of outcomes in addiction and the degree of choice exercised in bringing about those outcomes.

For example, Halpern cites the difficulties that people have in quitting smoking (studies of addicts regularly report nicotine among the drugs that are most difficult to quit). Yet half of all addicted smokers in the United States have now quit, and the large majority did so without formal treatment or self-help programs of any type. Question any table of 10 or more people, and you will find multiple miracle self-cures!

In fact, surveys of drug and alcohol users, including those deeply dependent on the substances, regularly yield similar results. Consider Deborah Hasin, Ph.D., and colleagues' study of untreated heavy drinkers over time, comparing those drinkers with *DSM-IV* alcohol-dependence assessments at baseline with those without such diagnoses (*J Stud Alcohol* 2001;62[4]:509-517). This study found that dependent subjects show a significantly greater percentage of drinking reductions.

> According to clinical expectation, individuals with a current diagnosis should be less likely to reduce (control) their drinking than individuals without such a diagnosis. We studied the question longitudinally among nonpatients, using different ways of measuring alcohol consumptions and different statistical strategies. No strategy supported the hypothesis.

At the same time, addiction treatment on the most modern medical basis often fails to improve upon natural outcomes. In his references, Halpern cites but does not discuss the first multisite trial in alcoholism treatment in men using naltrexone (ReVia). Results showed no greater reduction in drinking from naltrexone than placebo (N *Engl J Med* 2001;345[24]:1734-1739).

To deny people's regularly demonstrated ability to reduce or cease self-debilitating behaviors, no matter how powerfully embedded in their lives, is to minimize the opportunity and the fact of change in smoking, drinking, drug use and so on, even for those reckoned as addicted by diagnostic tools. That people retain tremendous discretion in attacking addictions is critical for our public health and treatment efforts, which should both recognize and support—indeed, treatment should build on—such self-efficacy.

Stanton Peele, Ph.D., J.D.
Morristown, N.J.

Dr. Peele is a senior fellow of the Drug Policy Alliance, a Washington, D.C./New York drug policy reform organization. His most recent book is The Meaning of Addiction: An Unconventional View (*Jossey-Bass Publishers*).

I start with the assumption that we are asking the question, "Is addiction a choice or a disease?" in the context of psychiatry. Psychiatry is a medical science. We have no business engaging in unscientific speculation. To consider a behavior to be a choice requires that we say the person had the free will to make that choice. The concept of free will has no place in science. It implies a causeless cause, which not only seems logically absurd but flies in the face of our clinical knowledge. The whole point of psychiatry is to understand the causes of illness and the means to ameliorate the disorder. Only the scientific method enables us to make progress on this task. How can a scientist assert that the cause of a phenomenon is a person's choice to do so independent of any influences? The entire enterprise of psychiatry falls apart if we grant such an assertion.

Yes, we do have the subjective conviction that we feely make decisions. However, we need not credit that belief with truth just because we have subjective experience. We know our subjective states need not reflect reality. The moon seems larger near the horizon. Knowing of this illusion enables us to discount it

Giving up a belief in free will for the purposes of psychiatric treatment does not require that we give up any useful medical treatments. The addict requires persuasion to follow the treatment program. Effective persuasion means we have influenced the person. Putting free will into the equation merely muddies the waters. The legal system as such requires that we accord the accused the presence of free will in order to consider them innocent or guilty. I don't see why we psychiatrists must alter our concept of illness because of the needs of the legal system.

Arthur Rifkin, M.D.
Glen Oaks, N.Y.

Dr. Rifkin directs an inpatient service for mentally retarded adults with psychiatric disorders and is also in private practice.

Dr. Schaler responds:

I appreciate Drs. Peele and Rifkin's opinions regarding my assertion that addiction is a choice, not a disease. Bodies are diseased. Behavior refers to something people do.

Dr. Peele agrees that mindset and environment are key to comprehending addiction. Privileged and underprivileged people alike self-destruct for existential reasons—nothing causes them to do so.

Dr. Rifkin confuses theory about why a behavior occurs with a description of the behavior itself. There is no such thing as involuntary behavior, and there is nothing unscientific about the exercise of free will. Choice is what characterizes us as uniquely human, not psychiatry as science.

Jeffrey A. Schaler, Ph.D.
Silver Spring, Maryland

Dr. Schaler is a psychologist and adjunct professor of justice, law and society at American University's School of Public Affairs in Washington, DC.

Dr. Halpern responds:

Dr. Peele is in error in suggesting that my argument that addiction is a disease is generalized to all users/misusers. Any substance can be used or abused, and physicians well know that medications have specific parameters for safety. That individuals diagnosed with alcoholism reduce their consumption over time versus nonproblem drinkers is also extraneous to this debate (*J Stud Alcohol* 2001;62[4]:509-517).

Although Dr. Peele reads otherwise, my article did indicate that naltrexone failed to be effective in a multisite trial to treat alcoholism (*N Engl J Med* 2001;345[24]:1734-1739). Again, this failure may be due to giving naltrexone qd as opposed to prn for increased cravings (*Alcohol Clin Exp Res* 2001;25[suppl ISBRA]:127S-131S).

It would be misleading to buy into Dr. Peele's argument that because millions of individuals stop smoking tobacco on their own, we should ignore the disease model of addiction and instead focus on the you-have-power-to-quit platitudes to our patients. While the tobacco industry might hail such assertions, this tremendous discretion proves

insufficient. According to the Centers for Disease Control and Prevention, 430,000 Americans die every year now because of their addiction to tobacco. Drug education and promoting self-efficacy are part of treatment but clearly fall far short of what is needed.

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