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A Disease Concept for the 21st Century

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

Toward a Better Disease Model

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

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

The Tower of Babel.

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

E.M. Jellinek, in his classic 1960 text, noted that the debate over the disease concept was plagued by too many definitions of alcoholism and too few definitions of disease. The continued proliferation of terms and their unclear meanings (alcohol/drug dependence/abuse/addiction/problems, chemical dependency, substance abuse/misuse, disease, illness, sickness, malady,

condition, habit) has created a virtual Tower of Babel within the on-going disease concept debate. To transcend the unproductive rhetorical excesses of this debate, a basic vocabulary of words and meanings must be forged.

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

Alcoholism to Addiction

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

Boundary Integrity

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

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

Addictions versus Problems

The new disease concept will place alcoholism/addiction within a larger umbrella of alcohol- and other drug-related problems. The consumption of alcohol and other drugs

contributes to a large spectrum of personal and social problems: fetal drug exposure, drug-impaired driving, drug-influenced crime and violence, and underage and binge drinking, to name just a few. An undefined portion of these problems are not the product of alcoholism and other drug addictions, do not constitute “disease” states, and should not have a traditional disease model of intervention applied to them.

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

The field of professionally directed addiction treatment cannot have it both ways. It cannot (without great harm to itself and its clients) continue to clinically define alcoholism and addiction in narrow terms and then, for reasons of professional and institutional gain, misapply this narrow model to an ever-expanding array of drug-related and non-drug-related problems. If the field continues to rely solely on a narrowly prescribed addiction intervention model, then ethically it must refuse to treat the wider pool of individuals with AOD problems for whom this model is inappropriate and potentially harmful. If the field embraces the larger spectrum of people with AOD (and other) problems within its purview (which it has), then it must significantly expand its potential treatment goals and intervention technologies (which it has not).

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

Disease Variability

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

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

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

1. addiction is not caused solely by genetic or biological factors but by multiple interacting factors, a status that places it squarely within the rubric of other chronic diseases,
2. not all addictions are progressive (accelerating), some remain stable but enduring while others decelerate, just like many other chronic diseases,

3. patterns of spontaneous remission and maturing out exist in addiction just as they do with many other chronic diseases, and
4. the movement from an AOD problem to a level of continued alcohol and drug use below the priming dose of problem activation is common in those with transient AOD problems but rare in those with patterns of severe and persistent addiction.

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

Comorbidity

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

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

Role of Human Will

The new disease concept of alcoholism /addiction will define the role human will and personal responsibility play in the onset, course, and outcome of AOD problems and of alcoholism/addiction. Are alcoholics/addicts responsible moral agents who perpetrate acts of mayhem on themselves, their families and their communities, or are they victims of a disorder that undermines their values and best intentions? What is the effect of the answer to this question upon the individual alcoholic/addict and upon the society in which he or she resides?

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

It will be helpful to plot the degree of freedom one has to use or not use across the stages

of problem development and problem resolution. Alcohol/drug use, addiction and recovery are best portrayed not in terms of complete control and complete lack of control but in terms of degrees of diminishment or enhancement of voluntary control. Once educated, each person has a responsibility to:

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

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

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

The Variety of Recovery Experiences

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

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

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

Recovery Management

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

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

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

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

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

A Final Word

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

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

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

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

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