British Journal of Addiction (1990) 85, 1425–1427

COMMENTARY

Trivializing dependence

JEROME H. JAFFE, M.D.

National Institute on Drug Abuse, Alcohol, Drug Abuse & Mental Health Administration, Rockville, MD 20857, USA

Abstract

There are a number of repetitive behaviors which have in common what appears to be a decrease in an individual's capacity to choose to discontinue them. The taxonomy we select to categorize these behaviors depends on our objectives. Broad definition which label as 'addictions' both repetitive use of drugs and repetitive behaviors not related to drug use call attention to the loss of flexibility that the behaviors have in common. However, such broad definitions may overemphasize the value of general behavioral approaches to change and obscure the fact that seemingly similar behaviors can be dramatically changed by very different specific interventions; (for example, nicotine gum for cigarette smoking, clomipramine for obsessive compulsive disorder.) It is also possible that calling both compulsive hair-pulling and daily heroin use 'addictive disorders' may trivialize the concept of addiction and lead to an erosion of public support for research and intervention in the chemical addictions.

English is not unique in using a single word to describe that diverse category of human behaviors which have as a common feature a seeming decrease in capacity to freely choose to engage in what others perceived to be voluntary behaviors. Especially in recent years, the word addiction has been applied to behaviors as different as using drugs, ingesting food, gambling, hand washing, spending money, exercising, loving too much, or engaging in sex too frequently or too indiscriminately. In other languages and sometimes, still, in English, suffixes such as 'mania' or 'sucht' may be attached to such behaviors as in toxicomania, nymphomania, morphiumsucht or cocainsucht. The common denominator is that the individual appears to others to have diminished control over the behaviors or reports a sense of disequilibrium, loss, distress, or craving when the object or substance is unavailable or the behaviors are curtailed. Efforts to identify similarities across such diverse behaviors have been attempted by a number of workers (Miller, 1980; Orford, 1985; Peele, 1985; Brewer, 1988; Levison, Gerstein & Maloff, 1985). In his brief editorial, Isaac Marks has performed a useful service by pointing to still additional common features that the chemical addictions appear to share with those behaviors that he and others have now labelled "behavioral (non-chemical) addictions." The present effort deserves serious attention, not only because it examines these commonalities systematically, but also because, drawing upon experiences for the treatment of behavioral addictions, Marks makes a few concrete suggestions that would require us to change the ways we attempt to intervene in the chemical addictions. In the limited space allotted for commentary, it is not possible to discuss the advantages and disadvantages of using a broad definition of addiction to refer to diverse non-chemical using behaviors. In general, in dealing with behaviors, wanted and unwanted, the taxonomy we select depends on our objectives. Just as it is sometimes useful to think of light in terms of

wavelength and at other times in terms of photons, there are times when it is useful to see compulsive gambling, alcohol dependence and heroin addiction as kindred phenomena, but there are also times when it is far less appropriate to do so.

In his paper, Marks makes the case for a broad definition of addiction and suggests some novel approaches to treatment of drug dependence. For example, rather than ameliorating distressful withdrawal syndromes, we might try having patients experience them in order to learn that they are transient and need not therefore control behavior. Such toleration of distress seems to be useful in dealing with patients with panic disorder and phobia. Some of these ideas will no doubt be subjected to appropriately controlled clinical trials. Still others may flow from this very broad generic concept of addiction, even if the specific suggestions made in Mark's paper are not found to be useful. But, there is also a very different view: even drug syndromes that seem to have so much in common and to which we now apply a single set of criteria for determining the degree to which dependence is present (DSM-III-R) may themselves be diverse and similarities along several dimensions as described by Marks may mask important etiological differences that have profound implications for treatment.

When I was a medical student more than 30 years ago, we were taught that despite virtually identical clinical presentations, hemophilia was not a single entity and that two distinct defects in control of blood clotting had been found. Now medical science recognizes at least nine distinct subtypes of hereditary bleeding tendency based on the specific biochemical defect involved. Over the same interval additional distinct causes of hypertension and several varieties of elevated blood lipids have been elucidated, and the knowledge of the specific mechanisms has opened new possibilities for intervention. Accepting such mechanistic diversity does not mean that we should disregard more general interventions for hypertension or heart disease such as sensible diet, exercise, and stress reduction.

There is no fundamental incompatibility between the search for specific mechanisms and treatments and the recognition that some general procedures may have value across a group of problems that involve a very different weighting of the etiological factors. Similarly, we should not let our urge to find commonalities among repetitive behaviors and drug using behaviors interfere with our obligation to search for etiological specificities and mechanisms. Some specificities have already been demonstrated and translated into useful interventions. For example, some regular tobacco users are significantly helped by nicotine gum or a nicotine patch (Mulligan, *et al.* 1990; Rose *et al.* 1990), adjuncts to treatment which are unlikely to be useful for gambling, hair-pulling or obsessive–compulsive disorders. On the other hand, some smokers do not find nicotine gum effective and respond better to general behavioral interventions. Daily doses of methadone seem to be very helpful for some who are dependent on opioids, but this is not a treatment that one would recommend for 'compulsive' joggers. Despite Marks's comments on behavioral approaches that are useful for obsessive–compulsive disorders, those who have struggled for years to deal with this difficult to treat syndrome have been gratified by the progress made in finding useful pharmacological interventions such as clomipramine (Leonard *et al.*, 1989).

Quite apart from a concern that a broad definition might de-emphasize the importance of searching for specific mechanisms, there are other reasons to be cautious about such definitional shifts. Any taxonomy that places unwanted repetitive behaviors not involving reinforcing drugs in some super-category along with behaviors which do, does more than suggest that the two subcategories are related; it also tends to minimize any imporant distinctions that exist between them. There are some who would see this as an advance in thinking. For example, Peele (1990) has asserted that the "modern 'scientific' view of addiction has actually caused addictive behaviors to grow [because] it excuses uncontrolled behaviors and predisposes people to interpret their lack of control as the expression of a disease that they can do nothing about." Peele suggests that there are no fundamental differences between chemical addictions and many other behaviors which require people to choose among alternatives, and sees the very concept of addictive diseases as 'pseudo-science' antithetical to an emphasis on willpower, self control, and values. Admittedly, there is a tendency, especially by the laity, to interpret the notion of an addictive disorder as implying a total loss of control; Alcoholics Anonymous and other self-help groups do require members to concede that they are 'powerless over alcohol' (or some other substance). However, to assert that all scientists see drug dependence disorders as implying a total loss of control over drug intake is to set up a convenient 'straw man', a

useful debating device, but hardly a means to advance understanding. Most of those who view themselves as behavioral scientists recognize that all behaviors, including repetitive drug-using behaviors, have multiple determinants: history, genetics, biology, beliefs and current circumstances all play a role. It is not a denial of the importance of willpower, values, or beliefs to suggest that, other things being equal, a very thirsty man may need far more willpower to resist consuming a glass of water placed before him than a man who is not at all thirsty. The core idea common to the chemical addictions as used by scientists is not that the individual is 'powerless' over the drug, but that as a result of a number of possible factors, the importance of which vary across drug categories and among individuals, the individual's freedom to choose is diminished, relative to that freedom at some prior point. Given sufficient motivation, even those who are thirsty can refrain from drinking; drug users can and do elect to stop using substances (or ask others to help them do so) even as they report that they feel out of control. Recognizing that there is something about the interaction between certain drugs and people that leads some people, at least temporarily, to exhibit a diminished freedom to choose to continue to use, and to set out criteria about when such a condition might merit clinical attention, is to describe a common human situation, not to explain it.

In addition to the role of learning and habit formation, the explanations for diminished flexibility or freedom to use a drug may sometimes include an inability or an unwillingness to tolerate withdrawal. Other factors may include drug induced changes in the very decision-making apparatus itself, the brain; inherent differences in the way drug effects are perceived, or in some sense of distress that is alleviated by the drug. While these factors alone are usually not sufficient to explain why some continue and others stop, to attribute the behavior to inadequate motivation, an absence of willpower, or inappropriate values is to abandon the effort to understand how drugs can come to play such important roles in the lives of so many people. Looking for commonalities across chemical and non-chemical addictions can be heuristic. However, to the degree that seeing these behaviors as members of a supercategory suggests that they are all amenable to behavioral interventions, inspiration, or changes in values and beliefs, we risk the trivialization of some of the commonest and most destructive of human problems.

The task for those seriously interested in advancing knowledge in this field is to take the best of ideas and remedies that are uncovered by each of these very different perspectives on human problems, test them in the furnace of well designed clinical trials, and keep and use those which emerge unscathed (or only a little singed) from the fire. What terminology we use is secondary as long as it does not cloud our vision.

References

BREWER, C. (1988) The management of opiate abuse: Learning from other addictions, *Journal of Drug Issues*, 18, pp. 679–697.

LEONARD, H. L., SWEDO, S. E., RAPOPORT, J. L., KOLBY, E., LENANE, M. C., CHESLOW, D. L. & HAMBURGER, S. D. (1989) Treatment of obsessive-compulsive disorder with clomipramine and desipramine in children and adolescents, *Archives of General Psychiatry*, 46, pp. 1088–1092.

LEVISON, P. K., GERSTEIN, D. R. & MALOFF, D. R. (1985) *Commonalities in Substance Abuse and Habitual Behavior* (Lexington, Lexington Books, D. C. Heath).

MILLER, W. R. (1980) The addictive behaviors, in: W. R. MILLER (Ed.) *The Addictive Behaviors*, pp. 3–7 (Oxford, Pergamon Press).

MULLIGAN, S. C., MASTERSON, J. G., DEVANE, J. G. & KELLY, J. G. (1990) Clinical and pharmacokinetic properties of a transdermal nicotine patch, *Clinical Pharmacology and Therapeutics* 47, pp. 331–337.

ORFORD, J. (1985) *Excessive Appetites: a psychological view of addictions* (Chichester, John Wiley).

PEELE, S. (1985) *The Meaning of Addiction: Compulsive Experience and Its Interpretation* (Lexington, Lexington Press).

PEELE, S. (1990) Editorial, The addict's values, *Baltimore Sun*, March 27.

ROSE, J. E., LEVIN, E. D., BEHM, F. M., ADIVI, C. & SCHUR, C. (1990) Transdermal nicotine facilities smoking cessation, *Clinical Pharmacology and Therapeutics*, 47, pp. 323–330.