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COMPETING CONCEPTS OF CHEMICAL DEPENDENCY

By David Macmaster

Introduction

It is certainly not new to have competing concepts of alcoholism and chemical dependency. We can predict that controversy and emotional "claim jumping" to new positions will continue. Loyalties will change. Authorities will defect to new schools of thought. Certainty will emasculate into doubt then crystalize into new and stronger convictions. Thus is the human experience of cognitive evolution and the metamorphosis of new and more fitting ideas. It is not a comfortable process.

It was not long ago that the featured competition for the "correct" concept about alcoholism was between alcohol abuse as a sin (the prevailing concept of a Puritan society) versus alcoholism as a disease – as promoted by a strange alliance of medical doctors and a small band of problem drinkers, once considered incurable, who no longer drank and identified themselves as "alcoholics."

Alcoholism as sick persons worthy of help and support won the day and subsequently a million or so problem drinkers responded to the new interpretation of their condition and sobered up. The word went out with the help of the National Council On Alcoholism under the leadership of Ms. Marty Mann, herself a self-admitted and recovered alcoholic. The answer to problem drinking was simple but difficult. Abstinence. While hundreds of thousands did stop drinking alcohol after the formation of Alcoholics Anonymous (AA) in 1935, millions of those who should have didn't.

Alcohol abuse remains an ever more-burdensome public health problem. Alcohol dependency is a fact. It exists, but what it is and what should be done about it remains an issue of controversy. Medical leaders who believe alcohol and other drug dependency (sometimes understood by psychiatrist and others) as "addiction" is a disease in need of a medical response, fail to convince many of their colleagues. Perhaps the majority of psychologists, particularly the behavior-oriented theorists, in the United States cannot accept the disease concept of alcoholism. The same is true of most "helping professionals." Nobody knows.

The competing concepts of what chemical dependency is, now appears to be between the reigning but battle-scarred champion - the disease concept – and the challenger alcohol/drug abuse, the maladaptive, learned behavior. Put another way, "Do we have it because we do it – or do we do it because we have it?"

From an historical perspective we could see the concept evolve from ancient times "spirits" perceived alcohol intoxication as demon possession. It has been known as a failing of character – a moral weakness. It was also a sin. It was a symbol of decadence and riotous living. It was called

a curse and an affliction – causes unknown. It became a disease. Then, for some, a syndrome of inter-related symptoms.

Additional pressure comes from bureaucratic agencies competing for funds (and therefore survival,) as they demand more administration, and we have to meet their demands at the expense of helping services. The reason? Competing concepts of how service is to be delivered and documented. This, because we can't prove we are doing much good even when we are giving our best efforts.

It is my contention that much relief from the occupational stresses of working in the chemical dependency/addiction field could be had by simplifying the existing concepts. We could synthesize them into a concerted, decade-long assault on drug and alcohol abuse problems and solutions.

In 10 years, another synthesis of newly revealed facts and truths could be accomplished. While many from the American tradition proudly proclaim, "competition is healthy and vital;" I respond, "The competing concepts of chemical dependency are not producing the standards of excellence we seeks. They are dividing us and may destroy us."

Note: A list of resources that helped shape the opinions expressed in this essay will be included at the end. The terms alcoholism and chemical dependency may be used interchangeably unless otherwise stated. Generally, they mean a pathological condition associated with a pattern of alcohol and drug abuse.

This essay is subjectively interpretive other than scholarly or authoritative.

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AN ESSAY

COMPETING CONCEPTS OF CHEMICAL DEPENDENCY IN 1980

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Introduction

There are competing concepts of alcoholism and other chemical dependencies. Even though much of the programming and funding for alcoholism has been based on the "disease concept of alcoholism" other theories and points of view continue to emerge to challenge that assumption.

Many authorities from the drug abuse field dispute the notion that dependency on any intoxicating drug is a pathological disease state. They prefer to identify drug abuse as a behavior engaged in for a variety of reasons by self-directed persons. Treatment, intervention, education, and prevention responses are therefore based on what the various national, state, and local programmers believe to be the true nature of alcoholism/chemical dependency.

These and other competing concepts create a host of problems for service providers trying to do an honest job of counseling or helping. I plan to identify some of these competing concepts and explore what they mean subjectively and to review some of the information I have searched out from the selected authorities in the fields of alcohol and drug abuse. I intend to consider these issues:

1. What is alcoholism/chemical dependency and how should the helper present the facts?
2. Competing treatment approaches?
3. Competing agencies/authorities?
4. Who should be treating substance abuse and chemical dependency/alcoholism?

To simplify, what are the problems? Who has them? Who should solve them? How should we do it? In my opinion, the CD professional (or para-professional) is a new breed of healthcare helper with insufficient political clout or status expected to control, manage and if possible, eliminate our most costly social and public health problem. We are to rescue the "afflicted" and train the "affected" to either survive in their misery or force a confrontation for early intervention. Some of us seem to be over-dedicated and under-educated. Others appear to be over-educated and under-dedicated. As professionals we are known to face early "burnout "because of the extreme stress of our work.

I believe much of this stress occurs because we are tormented by the constant flow of contradictory information about alcohol and drug abuse. It is difficult for the open-minded worker to know what is true about chemical dependency issues.

It has been described as an altered state of consciousness, not a behavior problem. Since there is no unanimous agreement about its cause or even what it is, should we be surprised at the lack of a cure we can all agree on? This brings us to the present spate of issues.

Is alcoholism a disease? Is drinking alcohol a symptom of an underlying psychological disorder or a learned or constitutional inadequacy? Is drug abuse a behavior disorder – a compulsion – a sociological phenomenon? Is chemical dependency the same thing as alcoholism? Is it inevitably pathological and can its progress be tracked? Can an alcoholic use other intoxicating substance safely? Can chemically dependent be trained to use, or drink differently? What biological factors are involved in chemical dependency? Is there a genetic or hereditary component to CD? Is alcoholism/CD a cultural anomaly?

These among other questions about chemical dependency perplex me. For instance, the drinking behavior of adolescents, which often is abuse pure and simple as opposed to social/responsible use, can mimic the abuse patterns of chronic alcoholics. Does this mean the abusing young person is an alcoholic and should be treated with the same responses used to intervene in a severe alcohol problem? Many of these youthful substance abusers use intoxicants at the high school and college levels but then their patterns of abuse adjust to safer behaviors. The label of "chemically dependent" no longer fits. Were they temporarily afflicted by a disease?

As an alcohol and drug abuse counselor, I often feel frustrated by the competing concepts of chemical dependency. I don't know what is true, what is half true – or what is false. The information about CD competes for belief – for a piece of my mind. It is well known dilemma of sorting out the relevancy of facts, theories, and ideas while at the same time having to present the information about CD authoritatively to patients and clients. The priest or parson who preaches theology he only partly believes would be another example of the same "crisis of faith." How can you sell what you don't really buy yourself?

Jellinek poses that alcoholism is a disease. Thomas Szasz says it is no such thing. It is self-defeating behavior well within the control of the individual. The American Medical Association, World Health Organization, The American Psychiatric Association, and many other prestigious professional associations define alcoholism as an illness within the province of the medical professionals. Alcoholics Anonymous experiences alcoholism as a disease featuring an allergy-type physical reaction combined with a powerful obsession that erupts unpredictable into a compulsion to drink – even against self-interest. McAuliffe says chemical dependency says chemical dependency is a pathological relationship between a person and a mood-altering chemical in the expectation of a rewarding experience.

Westermeyer lists eleven models for understanding chemical dependency, noting that no one model explains all the different aspects of the condition and favors a CD syndrome as the most useful model for defining chemical dependency. Jellinek reviewed the literature up to the 1950's and presented more than sixty concepts of alcoholism alone. These included physiological, sociological, and psychological theories.

Each of these concepts has merit. They seem to fit in some way, even if none are all-inclusive or very satisfying to the scientific mind. In 1980 we know more about CD than ever before in the broad sense of the knowledge. As the information competes for our acceptance like a horde of clamoring politicians, the working professional runs the risk of becoming too tentative under the burden of confusion. Instead of being extremely positive we may vacillate and reinforce the patient's highly tuned rationalization and intellectual defenses. If I can't explain what is wrong with him/her clearly, and without conviction, I may condemn him or her to years of additional

suffering while we both try to find an explanation of CD that covers all the bases for everyone who has it – whatever "it" is.

How many have already died because they couldn't accept the reality of their problem and needed a cognitive explanation for their condition before they could comfortably live with it?

My concern then is, how can I explain CD to people who have problems with alcohol or other intoxicating substances? I need to maintain my integrity of belief and conviction.

Yet, I also need to provide a rational explanation for clients that fits their individual and collective experience.

I can predict many of my clients will go through the same search for an understanding of their condition as I did. I need to anticipate how the conflicting information will affect their tenuous newfound sobriety or changed, drug-free lifestyle.

I choose to identify chemical dependency, first as a personal health problem that requires a differential evaluation or diagnosis by a specialist – or at least someone with an appropriate knowledge/experience base. I believe each CD "syndrome" has its unique features, case by case, yet has some universal characteristics. These characteristics are not usually all present in each case. You could say we are dealing with "varieties of chemical dependency." I believe Jellinek was on the right path in this regard.

I accept the premise that CD has learned behavioral features. Herein lies the greatest challenge and opportunity for its treatment.
Those who search for a biological cause and cure for alcoholism/drug dependence may dispute that opinion. Some researchers seem to be searching for the pharmacological response to prevent or reduce intoxication to safer levels. The promising research into endorphins by Goldstein of the Addiction Research Foundation in California is one example of the bio-chemical approach to understanding the dynamics of the physiological actions and reactions of psychoactive drugs. There are many others.

The physiological approach represents a powerful force in the CD field due to our high respect generally for the physical or "hard" sciences. The physiologists seem to have limited tolerance for the often intangible, anecdotal realities of the other competing concepts.

There probably are important physical causative factors in the CD syndrome. There may eventually be drugs to combat the condition. But I have little confidence that any drug will curb our insatiable appetite for intoxication even if one were available.

I don't believe that a person who is destructively dependent on one intoxicant is absolutely always going to be dependent on all intoxicants. Yet, there is considerable evidence that the chemically dependent person is at high risk for other substance abuse patterns. For example, sober alcoholics are very frequently heavy users of caffeine, nicotine, and over-the-counter drugs like aspirin. They often search for substitute intoxicants that are safer. This behavior is also observed in abusers of illicit drugs who switch to alcohol or settle for marijuana.

Current evaluative test questionnaires, like the National Council of Alcoholism Diagnostic Criteria, the Mulford Intake (Iowa) and the Michigan Alcoholism Screening Test will usually correctly identify an active alcoholic. Similar tests are apparently available for other drug abusers, or soon will be, (McAuliffe et al.) It is possible to accurately diagnose chemical dependency in most cases.

Inasmuch as alcohol abuse exacts a heavy toll on several of the body systems (such as the central nervous system (CNS) – and the gastro- intestinal tract (CI) it is reasonable and appropriate to have medical professionals lead, or share, the assessment process if they are adequately trained. However, alcoholism and other drug dependence should not be perceived as an exclusively medical problem to be solved by medical professionals alone. The psychological and behavioral aspects of CD are often best treated by non-professional volunteers for part of the recovery process.

I am comfortable having medical people supervise the diagnostic process. I don't like the idea, however, that the chemically dependent person is "sick" if that label is applied to generate sympathy or serves to excuse the alcoholic or other drug dependent from facing the consequences of his/her behavior while intoxicated.

The fact is, that alcohol/drug abuse is a serious public health (and public safety) problem as well as being a personal health and safety problem. Unacceptable destructive behavior should not be tolerated nor swept under the rug. To do so is a grave disservice to the afflicted person who needs to feel the pain and discomfort to change. It is a negative and, I believe, self-serving response by a society lacking the courage to discipline itself.

I prefer the alcoholic and drug-dependents be told they have a condition that is pathological if not treated. They need to know they are at high risk for physical, social, psychological, financial and legal problems that is potentially life threatening. They need to be honestly advised that controlled use has been found to be an unreachable goal for most alcoholics and probably for all other drug dependent persons.

Who should diagnose, evaluate, and treat the alcoholic/chemically dependent? "Only as alcoholic can understand an alcoholic" is an opinion common among AA members who were frustrated by other and presumably, less successful approaches, at least as experienced by those members who regard non-alcoholics as being lacking in empathic sensitivity.

Others believe that skilled professionals should treat CD. The rationale seeming to be that only those with a special educational base in the so-called behavioral sciences can cope with the complexity of the intoxicating substance abuser.

Still others believe the afflicted persons should be placed in a protected environment or "therapeutic community" and that treatment becomes a group experience under guidance of either recovered chemically dependent persons or highly skilled therapists from the behavior modification school. Some "communities" have a mix of both facilitator/helpers.

Some are convinced no professional treatment or diagnosis is necessary believing that CD responds best to mutual-help groups like Alcoholics Anonymous or Narcotics Anonymous.

Dr. Harold Mumford of the University of Iowa is persuaded no current treatment works very well according to his research. He offers that the problem is that our drinking norms are the culprits – that until these are modified, efforts to reshape the drug abuser will fail.

What is the service provider supposed to do with this array of competing concepts? How should we help? What kind of treatment offers the best chance of success?

No sooner do we become satisfied that abstinence is the appropriate response to problem drinking and drug abuse the Rand Report of the late 1970's suggests some alcoholics can be trained to drink under control. New enthusiasm for "an easier, softer way" than total abstinence increases. Groups modeled after "Weight Watchers "spring up to teach over-drinkers to gain control over their alcohol use. Their leaders suggest AA will become obsolete in a decade or two.

Treatment centers offer new alternatives to their patients – abstinence or lessons in controlled drinking. The goals shift from sobriety to improved drinking behavior and less problems, improvement rather than obliteration of the troublesome habit.

Chemical dependency is an incalculable problem. Immense also is the economics of it. Not only the social costs, but the financial opportunites for treating it both as a public health problem and responding to the individuals and their families who have "it." There is MONEY in "it."

That is no secret to those who are trying to get some of it. A 28-day in-patient treatment plan in a Midwest hospital costs more than $4,000. How much does six months in a therapeutic community go for?

What about the potential for third-party payments under medical health insurance? There are estimated 9,000,000 alcoholics alone in the United States. What will it mean if those family members, who are affected severely in their emotional/mental health because of someone else's chemical dependency, are identified as "co-dependents" and eligible for professional treatment under their health plans and Medicaid?

Talk about competition! Consider the self-serving as competing professionals struggle for their corner of the market. Psychologists advocating a behavioral approach with themselves as change agents. Individual or other type of psychotherapy at $75 an hour and an inexhaustible supply of alcoholics and their co-dependents not to mention the new poly-drug abuser and their affected family members. These services are available now for those who can afford it privately.

Then there are the medical professionals who were frustrated by uncooperative drunks and prescription sneaking drug addicts for decades. Now through educational efforts of the AMA and other professional associations, doctors are aware, not only of the better treatment approaches to CD, but now know they can profit financially from their interventions.

Who will win the jackpot? The stakes are high. Perhaps the competing professional factions will be able to compromise and divide the financial rewards and the work among them. They haven't found a way to do it yet.

It seems to me the behavioral psychiatrists and psychologists generally are coming out of the drug field (NIDA –National Institute of Drug Abuse.) The medical disease concept is paramount in the alcoholism community (NIAA –National Institute of Alcohol Abuse and Alcoholism.)

These two federal institutes have not yet synthesized their valid learning's in my opinion. Perhaps the differences on the issue of what chemical dependency is divides them in a hopeless antagonism –usually simmering just below the surface because both sides know the public money would dry up if these competing concepts were openly debated. So, it is guerilla warfare" flaring up in this professional and industry publications and journals occasionally that is the tip of the ideology iceberg.

Many psychiatrists and psychologists from the drug-treating and prevention communities appear to base some of their assumptions about CD on the well-worn notion that underlying CD is a constellation of emotional/behavioral and mental deficits that need to be dealt with as the goal of treatment and prevention. They suggest that if the abusers can get in touch with their feelings and their moods better, they will no longer need to misuse intoxicants. They can, therefore, use these substances safely and appropriately.

Authorities from the alcohol field say not so, that CD is a primary condition in most cases and will remain so even if significant insight and behavioral change occur.

Again, what is the service provider to do with these competing concepts? All these positions are advocated by well-meaning authorities who have experience and certainly the right to their assumptions – no matter how controversial. They deserve to be heard and respected by an open-minded professional community and public.

But where is the leadership coming from? I have no perception of a single voice booming out a clear signal of what CD is and what should be done about it. Instead, I am hearing the "conventional ignorance" instead of the "conventional wisdom – ignorance in the sense that there seems to be few with the comprehensive overview I seek.

I cannot say I have received much useful authoritative direction in my search for a clear, concise understanding of the problems of alcoholism and other chemical dependencies after almost a quarter of a century of seeking the "truth and the way." My statement may very well be an accurate reflection of the state of the art in 1980.

To me the tragedy is we know enough to do better if we could but merge, blend and synthesize what we know now. We have some of the answers. We do have more than enough safe ground from which to begin a decade of progress against alcohol/drug abuse problems.

We can identify the CD problem relatively early in its course.

We do have alternatives for its treatment in whatever syndrome it manifests itself.

Many of us accept the premise that abstinence will inevitably be the only remaining alternative for the majority of those with this syndrome – although we know the afflicted person will resist this solution and will try to control their use – even to death.

We are growing to understand the family and concerned others must be part of the treatment and re-education process.

We know the recovery period is approximately two years within a supportive environment with a structured personal program of growth and change.

Many of us recognize that a helping peer group offers the most successful support for both the afflicted and those affected by CD.

We have correctly established there are too many variables to permit a narrow diagnostic picture – that CD is best perceived as a syndrome until more effective differential diagnosis is possible through research and experience. This eliminates the need to argue over the best way to describe the condition with exactness. The syndrome can fit the syndrome. The person does not need to fit a rigid disease profile.

We have learned that service providers who are chemically dependent/alcoholic need more than the fact of their own recovery to qualify as professional counselors. We have also found that those whose qualifications are only academic and not experiential, i.e. they haven't a sensitivity to CD – are perhaps even more a liability than the "amateur counselor" who is at least highly motivated to help – even if in a clumsy manner. Substance dependents don't need an "I don't care" reception from judgmental professionals whose interest in their work is purely vocational.

We accept the reality of the physiological damage caused by alcohol/drug abuse. Medical responses are often the point of intervention in CD. The medical model offers the beginning point for recovery from this health problem. However, after appropriate medical evaluation and treatment is completed, CD seems to require an educational model to facilitate change. It is not feasible, nor practical, for physicians to do this laborious, time-consuming work although they may have a supervisory role.

We know many other truths about CD and some of the ways to deal with it. In the process we have proved that the non-degreed highly trained CD/alcoholism specialist can be trusted to manage the chemical dependency recovery and rehabilitation process.

As drug treatment and prevention programs are merged with alcohol services perhaps the hoped-for synthesis will take place and some of the current competing concepts will also merge into better action plans to combat alcoholism/chemical dependency and substance abuse. It shapes up to be a lengthy process with some bitter battles – few of which will probably help the consumer (the chemically dependent and their loved ones) in the short run.

We service providers will be "in the trenches doing our thing" anyway. We are seldom motivated by the competing concepts of chemical dependency. I am not. They just confuse me and remind me of my limitations. I don't need to know all the answers to care or to try to do my best. I don't need to be an electrical engineer or a physicist to use electric power. I don't need to comprehend everything about chemical dependency in order to be confident in my counseling of its victims.

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