BOOK REVIEW

Is Addiction Really 'Voluntary?'

J. CALVIN CHATLOS, M.D.

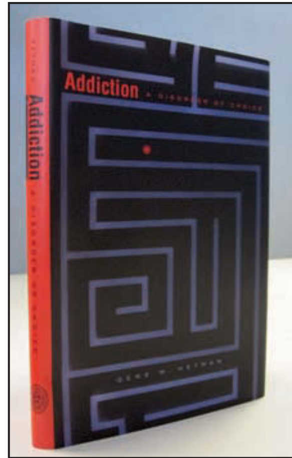
This book continues discussions about addiction that focus on the nature vs. nurture debate. The author, a research psychologist affiliated with McLean Hospital and Harvard Medical School, Boston, leans toward the role of nurture/environmental influences in explaining addiction.

In doing so, Gene M. Heyman, Ph.D., discounts addiction as a disease. This emphasis is not the book's key strength, however. Instead, it is Dr. Heyman's rich discussion about the voluntary vs. involuntary aspects of addiction that makes the book a significant contribution to the field.

In addition, this is a timely discussion in light of proposals to put an end to separate diagnoses for substance "abuse" and "dependence" in the DSM-5 (" 'Substance Use Disorder' Diagnosis Gains Favor," July 2010, p. 17). However, Dr. Heyman does not specifically address those controversies.

The opening paragraph of Chapter 5 has a wonderfully amusing commentary about how classifications can reflect different understandings of basic terms and lead to radically different (even scientifically wrong) conclusions. Of important note, Dr. Heyman clarifies that his use of the word "addiction" is synonymous with the DSM-IV definition of dependence rather than abuse. Indeed, most of his data are presented from the dependence perspective.

Dr. Heyman begins with a fascinating historical perspective showing different social responses to addiction phenomena. He begins with 17th and 18th century opium eaters – well-to-do people, drinking laudanum, medically related and often medically prescribed. What follows in the mid-19th century is a historical progression to opium smokers, including Chinese immigrants, opium dens, and smoking concentrated opium introduced by tobacco smoking (the true gateway drug in history).



The ideas of Gene M. Heyman, Ph.D., are novel.

History then progresses to the sniffers of the heroin synthesized in 1898 by the Bayer Co. What started as medicinal and curative for centuries became addictive, with the opium smokers and heroin sniffers leading – in the United States – to the Harrison Narcotics Tax Act of 1914, which essentially criminalized addiction.

The presentation in Chapter 3 of some personal accounts of mostly opiate and cocaine dependence helps build the case for his argument that "quitting drugs becomes part of the story of addiction" and that the claim that "addiction is a chronic disease may not be true" (p. 64).

Dr. Heyman presents very valid data, such as the Epidemiologic Catchment Area studies, from a "glass half-full" perspective that does not support addiction as a chronic disease. He highlights that most users do not become addicted and that, by age 24 years, 50% of addicts achieve remission. That percentage climbs to 75% by age 37 years, he writes, and only 16% enter treatment (p. 70). His perspective describes addiction as a limited self-correcting disorder rather than a chronic, relapsing disease. What explains the discrepancy between his conclusions and current thinking on addiction? Dr. Heyman points to research showing that addicts do worse in treatment than those who do not enter treatment. Most people who enter treatment programs have an addiction complicated by comorbid psychiatric disorders – which might account for this.

He emphasizes that epidemiologic research suggests that most addicts quit because of financial and family concerns as they mature out of it (p. 84). This leads to his message that whether addicts keep using drugs or quit depends to a great extent on their alternatives, implying that drug use is voluntary. These theories lead to his conclusion that addiction is not a disease.

At this point, he takes what I would call an unnecessarily antagonistic position and equates "disease" as being involuntary and nondisease as voluntary. In many ways, his real issue is not that addiction is not a disease but that addiction is voluntary. This leads to some unnecessary forays into the relationship of "self-destructive behaviors" defining addiction rather than DSM-IV "loss of control" defining addiction, and a somewhat confusing description of genetics being related to either voluntary or involuntary behaviors, rather than to both, depending on the genetic variance.

As with many books about addiction, subtleties in language and simplification of relationships often lead to seemingly opposite conclusions. This book is no exception and is sure to be controversial in some settings. However, I hope that the novelty of Dr. Heyman's ideas about addiction occurring as a choice and his detailed elaborations will be fodder for further research – and integration toward more effective prevention and treatment protocols. ■

DR. CHATLOS is a psychiatrist certified by the American Board of Addiction Medicine. He also serves as associate clinical professor of psychiatry at the University of Medicine and Dentistry of New Jersey, New Brunswick.

COMMENTARY

A Call for More Global Collaboration

This year's theme for World Mental Health Day is a reminder that we psychiatrists must work closely with our colleagues not only in primary care but also in cardiology, endocrinology, oncology, and pulmonology.

AMIN A. MUHAMMAD GADIT, M.D.

The theme of the day, which is observed on Oct. 10, is "Mental Health and Chronic Physical Illnesses – The Need for Continued and Integrated Care."

We know that mental health greatly affects the management of chronic physical illnesses. The four major chronic illnesses mentioned by the World Health Organization – cardiovascular problems, diabetes, cancer, and respiratory illnesses – are responsible for 60% of the world's deaths, and 80% of these deaths are happening among the world's poorest populations. "If nothing is done, experts estimate that we could witness another 388 million people die prematurely within the next 10 years," authors of the 2010 report prepared by the World Federation for Mental Health (WFMH) wrote.

Not surprisingly, depression has the largest effect on worsening health, compared with other chronic illnesses. According to the report, depression is present in one of five outpatients with coronary heart disease and in one of three outpatients with heart failure, and most such cases go unrecognized. Negative lifestyle habits associated with depression – such as smoking, excessive alcohol consumption, lack of exercise, poor diet, and lack of social support – interfere with the treatment for heart disease.

Major depression puts heart attack victims at great risk and appears to add to the patients' disability from heart disease. It can contribute to a worsening of symptoms as well as to poor adherence to cardiac treatment regimens.

Based on global prevalence estimates of diabetes that were done in 2003, 43 million people with diabetes have symptoms of depression. Furthermore, people who have diabetes and depression have more severe symptoms of both diseases and higher rates of work disability, and they use more medical services than do those who have diabetes alone.

According to the WFMH report, studies suggest that depression increases the risk of developing type 2 diabetes more than 20% in young adults. Depression can lead to poor lifestyle decisions, such as smoking, alcohol abuse, weight gain, unhealthy eating, and lack of exercise.

About half of all patients with terminal or advanced cancer suffer with poor mental health. Adequate recognition of depression is important to enhance quality of life.

Overall, 20% of patients with asthma and chronic obstructive pulmonary disease suffer from major depression and/or anxiety. Studies suggest that psychopharmacologic and/or psychosocial interventions might improve asthma control. Depression and anxiety are associated with unhealthy behaviors, such as poor diet, physical inactivity, sedentary lifestyle, tobacco use, and heavy alcohol consumption. Many of these factors lead to obesity. Obesity has been associated with an increased lifetime risk for major depression and panic disorder. It is suggested that primary care services need to improve ways of screening for depression that is associated with particular chronic illnesses like heart conditions or diabetes.

The American Psychological Association suggests the following 10 ways to build resilience:

- ▶ Make connections.
- ▶ Avoid seeing crises as insurmountable problems.
- ▶ Accept that change is a part of living.
- ▶ Move toward realistic goals.
- ▶ Take decisive actions.
- ▶ Look for opportunities for self-discovery.
- ▶ Nurture a positive self-view.
- ▶ Keep things in perspective.
- ▶ Maintain a hopeful outlook.
- ▶ Maintain self-care.

Above all, integrated health care is vitally important in order to address mental and physical health problems. Such problems will remain unresolved and complicated if either part is ignored. The important aspect is the collaborative part of psychiatrists, our physician colleagues such as family practitioners, and allied mental health professionals in achieving the goal of addressing and managing this issue.

This, of course, is the right approach if we are serious about addressing global morbidity and mortality. Hence, the theme advocated this year by the WFMH is quite appropriate. ■

DR. GADIT is professor of psychiatry at Memorial University of Newfoundland in St. John's.