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On the Issues

Addiction Does Not Discriminate? Wrong

By Sally Satel, M.D.

In theory, anyone can become an addict. But it is a more likely fate for some than others. Suggesting that all of us are equally vulnerable does not reflect reality, and policy should not be based on that fiction.

We have heard it before: Drug abuse is an equal opportunity destroyer. Drug addiction is a bipartisan illness. Addiction does not discriminate; it does not care if you are rich or poor, famous or unknown, a man or woman, or even a child.

The phrase "addiction does not care" is not meant to remind us that addiction casts a long shadow—everyone knows that. Rather, it is supposed to suggest that any individual is vulnerable to the ravages of drugs and alcohol.

The same rhetoric has been applied to other problems, including child abuse, domestic violence, alcoholism, and even suicide. "Do not stigmatize the afflicted," it cautions. "You could be next. Be kind, do not judge."

The democratization of addiction may be an appealing message, but it does not reflect reality. Teenagers with drug problems are not like those who never develop them. Adults whose problems persist for decades manifest different traits from those who get clean.

So while anyone can theoretically become an addict, it is more likely the fate of some—among them women sexually abused as children, truant and aggressive young men, children of addicts, people with diagnosed depression and bipolar illness, and groups including American Indians and the poor.

Attitudes, values, and behaviors play a potent role as well. Imagine two people trying cocaine, just to see what it is like. Both are thirty-two-year-old men with jobs and families. One snorts a line, loves it, and asks for more. The other also loves it but pushes it away, leaves the party, and never touches it again. Do they have different values? Or do they have different tolerance for risk? Many factors may distinguish the two cocaine lovers, but only one is at risk of developing a problem.

Asking for more drugs is no guarantee of being seduced into routine use. But what if it happens? Jacob Sullum, a senior editor at *Reason* magazine, has interviewed many users who became aware that they were sliding down the path to addiction.

"It undermined their sense of themselves as individuals in control of their own destinies," Sullum wrote in his 2003 book, *Saying Yes: In Defense of Drug Use*. "And so they stopped."

I only read about these people. Patients who come to our methadone clinic are there, obviously, because they are using. The typical patient is someone who has been off heroin for a while—maybe because life was good for a while, maybe because there was no access to drugs, maybe because the boss did urine testing—and then resumed.

But the road to resumption was not unmarked. There were signs and exit ramps all along the way. Instead of heeding them, our patients made small, deliberate choices many times a day—to be with other users, to cop drugs for friends, to allow themselves to become bored—and soon there was no turning back.

Sally Satel, M.D., is a resident scholar at AEI. A version of this article appeared in the *New York Times* on September 2, 2008.

Addiction does indeed discriminate. It “selects” for people who are bad at delaying gratification and gauging consequences, who are impulsive, who think they have little to lose, who have few competing interests, or who are willing to lie to a spouse.

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Though the National Institute on Drug Abuse describes addiction as a “chronic and relapsing disease,” my patients, seeking help, are actually the exception. Addiction is not an equal opportunity destroyer even among addicts because, thankfully, most eventually extricate themselves from the worst of it.

Gene Heyman, a lecturer and research psychologist at Harvard Medical School and McLean Hospital, said in an interview that “between 60 and 80 percent of people who meet criteria for addiction in their teens and twenties are no longer heavy, problem users by their thirties.” His analysis of large national surveys revealed that those who kept using were almost twice as likely to have a concurrent psychiatric illness. None of this is to deny that brain physiology plays a meaningful role in becoming and staying addicted, but that is not the whole story.

“The culture of drink endures because it offers so many rewards: confidence for the shy, clarity for the uncertain, solace to the wounded and lonely,” wrote Pete Hamill in his memoir, *A Drinking Life*. Heroin and speed helped the screenwriter Jerry Stahl, author of *Permanent Midnight*, attain “the soothing hiss of oblivion.” If addiction were a random event, there would be no logic to it, no desperate reason to keep going back to the bottle or needle, and no reason to avoid treatment.

The idea that addiction does not discriminate may be a useful story line for the public—if we are all under threat, then we all should urge our politicians to support more research and treatment for addiction. There are good reasons to campaign for those things, but not on the basis of a comforting fiction.

Also by Sally Satel:

Article on Slate.com

Organ Failure

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Early this summer, the American Medical Association (AMA) voted to lobby Congress to permit the study of financial incentives for organ donation. With nearly one hundred thousand people on the national transplant list and eighteen dying every day for want of an organ, the AMA resolution to address the organ shortage could not be more timely.

And yet the National Kidney Foundation (NKF), the nation’s largest advocacy group for people with kidney disease, will not be a reliable ally. The NKF, which has a $32 million annual budget and is to kidney disease what the American Lung Association is to asthma, says it laments that thousands “die while waiting for that ‘Gift of Life.’” But instead of locking arms with the AMA, the kidney foundation is poised to sabotage the association’s efforts—in keeping with its recent practice of blocking any attempt to explore the possibility of compensating organ donors. Why the stubborn opposition? . . .

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