Book Reviews

Curtis Steele, Editor

Addiction: A Disorder of Choice
By Gene H. Heyman
Harvard University Press, 2009
200 pages, $26.95

Reviewed by Arthur V. Hohmuth

In this relatively brief text, Gene Heyman, a research psychologist at McLean Hospital and lecturer at Harvard Medical School, challenges a common belief concerning addictions. Textbooks, research papers, and government publications often view addiction as a chronic, relapsing brain disease. The author argues that addiction can be best defined as self-destructive voluntary behavior. Like all voluntary behavior, it is controlled by contingencies of reward and punishment. The fact that drugs produce changes in the brain is not a reason to classify addiction as a disease. Many repeated voluntary activities have been shown to produce changes in the brain. All cognitive and behavioral events have neural correlates.

Clinical data suggest that most addicts who enter treatment relapse, supporting the idea of chronic brain disease. One major review of rehabilitation programs concluded that between 80-90% of addicts relapsed within a year of completing a program. Other follow-up studies report similar results. However, the clinical data is based on a nonrepresentative sample. According to one epidemiological survey, only 30% of addicts ever mentioned their drug problem to a health professional. According to another, only 16% of people meeting the criteria for substance dependence were in treatment.

Four large studies using representative random samples of the population tell a different story concerning relapse and remission. The 4-year epidemiologic catchment area study (Robins & Regier, 1991) collected interviews from 19,000 subjects. Of those who ever met the criteria for addiction, approximately 75% were symptom free by age 37. Most had not been in treatment. Of the three other large-scale studies, one indicated a remission rate of 74% and the remaining two showed remission rates slightly above 80%. A smaller study of Vietnam veterans indicated that only about 12% of those addicted to opiates in Vietnam continued their addiction on returning home. In an effort to put a human face on the large numbers of addicts who quit, Heyman cites interviews with several such people. The common theme in their narratives is that they quit when the costs or anticipated costs (both financial and social) of continued use became too great to endure.

The vast discrepancy between the clinical outcome data and the epidemiological data calls for an explanation. The answer may lie in the fact that addicts who seek treatment are more than twice as likely as those not in treatment to have additional psychiatric disorders. Some may be using drugs to self-medicate for these disorders. Also, comorbid disorders make it more difficult to engage in satisfying alternatives to drug use. If we assume that drug use is a choice, those with greater access to satisfying alternatives will be most likely to quit.

Heyman argues that no one chooses to be an addict; after a frequently rewarding first experience, a person chooses to use a drug one more time and then again one more time. Each choice is determined by the relative value of using versus not using. The same motivational principles that drive adaptive choices also drive addiction. Faced with a series of choices, there are at least two ways to make decisions. One (local choice) is to, at each choice point, choose the option that has the highest value at that moment. The other (global choice) attempts to choose the most valued sequence of choices. Numerous studies show that humans are biased toward making local choices, which are simple and direct. Global choice is more intellectually demanding, requiring both imagination and forethought. The fact that the cost of drug use is in the future, and uncertain, makes global choice all the more unlikely. Also, continued drug use reduces the value of nondrug activities. Intoxication

and withdrawal interfere with normal interactions. Local choice often leads to suboptimal long-term value and, in the case of drugs, to disastrous long-term value.

From a local perspective, when an individual quits using, the value of a nondrug day is clearly less than that of a drug day. For this reason, it is desirable to have programs that make drug access impossible during the first weeks of abstinence. Conditions must also be created to encourage a global choice strategy and simultaneously to increase the value of nondrug alternatives and also to decrease the value of drug choices. The case studies of people who quit suggest that shifting from local to global thinking was one stimulus for recovery.

Heyman provides examples of treatment programs with "immediate and salient consequences" (p. 86) for drug use or abstinence. In 10 treatment programs set up for airline pilots and physicians, relapse could have meant job loss. Nine of the 10 programs included random drug tests. For these programs, recovery was in the 80-90% range. For the one program without drug testing, the recovery rate was closer to 60%.

Steve Higgens of the University of Vermont reports impressive success in the treatment of cocaine addicts. Patients received traditional counseling and were tested several times a week. In addition, if metabolic evidence indicated they were drug free, they received a voucher that could be traded for modest but desirable goods. The vouchers increased in value for continued abstinence but never exceeded $12. Approximately 70% of these patients were drug free for the first five weeks of the program compared to 20% for a control group that received traditional counseling only. A follow-up study showed that the abstinence rate not only continued but actually increased to 80% a year after treatment. A 2006 meta-analysis concluded that "contingency management is 'one of the most effective' treatments for chemical dependency" (as cited in Heyman, p. 108).

Addiction studies is a complex field. Various writers have focused on brain chemistry, genetics, cultural and environmental variables, economic variables, and values. Heyman recognizes the importance of such factors but believes their impact is determined by the effect they have on the relative value of different choices. For example, opium first became a problem in China in the 1700s. Heyman believes this was because of the existence of a leisure class with extra time and money and because alcohol was not readily available as an alternative. The relatively high rate of opiate addiction among American soldiers in Vietnam is explained in terms of ready availability, limited alternate behaviors, and little fear of punishment. The immediacy of combat would also decrease the likelihood of global decision making. A similar analysis is made for higher rates of drug use among the very poor and among those in larger cities. Brain chemistry and genetics are thought to influence the relative value of drug use.

Heyman also discusses alcohol and tobacco. He praises Alcoholics Anonymous (AA) for encouraging global choice and providing rewarding social alternatives to drinking. Tobacco is viewed as a special case because, until the recent restrictions on smoking, it was fully compatible with other rewarding activities. In the form of nicotine gum, I suppose it still is.

Heyman's core message is simple: Drug use is instrumental behavior driven by its consequences. While this view may deemphasize other important considerations, it is interesting to see how far he extends it to explain a large portion of available data. At points I wanted more information. For example, I would have liked to know the demographics of the Vermont studies. I would have liked information on more programs incorporating contingency management. Have particular programs proven effective with certain demographic groups? The meta-analysis mentioned looked at 47 studies that compared contingency management programs with control groups. Are all the results as impressive as the three studies Heyman presents in detail or did he simply pick the most dramatic results and thus overstate his case?

Heyman's book will be read with interest by anyone involved in the prevention or treatment of drug addiction as well as by those engaged in work with individuals who engage in any form of voluntary self-destructive behavior.

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REFERENCE

Robins, L. N., & Regier, D. A. (Eds.). (1991). *Psychiatric disorders in America: The epidemiologic catchment area study.* New York: Free Press.

Tales from the Therapy Room: Shrink-Wrapped
by Phil Lapworth
Sage, 2011
168 pp., $89.95

Reviewed by Charlotte Sills

This book is a delight. It is comprised of ten fictional stories told in the first person by a fictional therapist. The stories offer a fascinating cast of characters, from Cheryl, the sultrily beautiful romantic in search of love; to Luke, the spiritually wounded 40-something; to Lee, the young offender "wired like a whippet in a cage." Each story addresses a different aspect of the therapeutic endeavor, including the challenges of any therapist's consulting room: boundaries, misunderstandings, working in and with relationships, working with sexuality or spirituality, and so on. Some concern more unusual circumstances — from the transpersonal to the theatrical. Each story invites us into the usually unseen world of the therapy room to witness what goes on between therapist and client and, particularly, what the therapist feels and thinks during and between sessions as he endeavors to engage effectively with the situation.

A taste: In "Holding Boundaries," the therapist faces the dilemma of what to do with his suspicion that two of his clients may be meeting outside the therapy room. "The Carving" explores the nature of the therapy room itself and how the introduction of a wooden carving affects each client differently and how one client employs the carving to his own ends. "In at the Deep End" concerns trust in relation to both client and therapist. In an ironic turning of tables, the therapist (along with the reader) is left unsure as to what he can and cannot trust, while his client, having worked through her rather paranoid approach to life, goes off swimming with sharks!

Readers will wonder to each other, who is the therapist in these stories? Certainly not Phil himself. Phil never wears a suit! Whoever he is, the richness of the stories lies in the blend of qualities that are, without doubt, a fundamental part of the author. On the one hand, we feel Phil's loving sensitivity and understanding for the human condition, and the stories are, at times, deeply moving. On the other hand, an irrepressible humor shines through the words. I love that some of the situations take the therapist completely by surprise while others — ones that I might find difficult — seem to leave him unfazed. Yet they are all written with a wry, amusing wit while never failing to take seriously the client's plight. I laughed out loud many times.

Perhaps the cherry on the cake is Chapter 11, "Unwrapped through Discussion." The therapist muses and reflects on the stories, taking them seriously as real therapeutic situations. He shares how he thought clinically about the client and the situation, how each can be discussed theoretically, his clinical choice points, the options he had, and why he made the decision he did. He invites readers to think about their own thoughts and opinions: What would they have done in that situation? How else could the issue be addressed? Phil offers some provocative questions to stimulate debate.

Lay readers may not bother to read Chapter 11 but still derive enormous pleasure from the book, particularly if they have ever been in therapy or contemplated it. The book does "unwrap" the person of the therapist in a delightful way. But for the therapist reader, engaging with Phil's thinking and clinical decision making offers rich learning and adds an exciting dimension to the book. I recommend it to every trainee of any approach to counseling or psychotherapy and to all qualified practitioners who want the opportunity to be entertained and to take part in a collegial debate in the comfort of their own home!

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