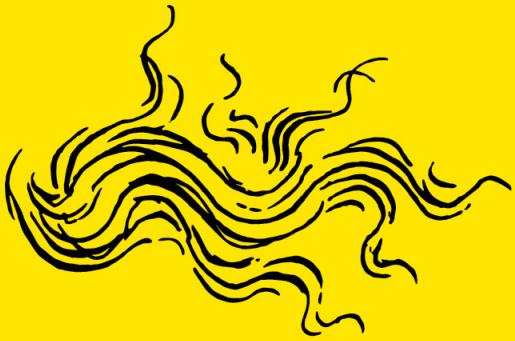
CULTURE AND POLITICS

Liberties



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SALLY SATEL

Dark Genies, Dark Horizons: The Riddle of Addiction

In 2014, Anthony Bourdain's CNN show, *Parts Unknown*, travelled to Massachusetts. He visited his old haunts from 1972, when he had spent a high school summer working in a Provincetown restaurant, the now-shuttered Flagship on the tip of Cape Cod. "This is where I started washing dishes ...where I started having pretensions of culinary grandeur," Bourdain said in a wistful voiceover. For the swarthy, rail-thin dishwasher-turned-cook, Provincetown was a "wonderland" bursting with sexual freedom, drugs, music, and "a joy that only came from an absolute certainty that you were invincible." Forty years later, he was visiting the old Lobster Pot restaurant, cameras in tow, to share Portuguese kale soup with the man who still ran the place.

Bourdain enjoyed a lot of drugs in the summer of 1972. He had already acquired a "taste for chemicals," as he put it. The menu included marijuana, Quaaludes, cocaine, LSD, psilocybin mushrooms, Seconal, Tuinal, speed, and codeine. When he moved to the Lower East Side of New York to cook professionally in 1980, the young chef, then 24, bought his first bag of heroin on the corner of Bowery and Rivington. Seven years later he managed to quit the drug cold turkey, but he spent several more years chasing crack cocaine. "I should have died in my twenties," Bourdain told a journalist for *Biography*.

By the time of his visit to Provincetown in 2014, a wave of painkillers had already washed over parts of Massachusetts and a new tide of heroin was rolling in. Bourdain wanted to see it for himself and traveled northwest to Greenfield, a gutted mill town that was a hub of opioid addiction. In a barebones meeting room, he joined a weekly recovery support group. Everyone sat in a circle sharing war stories, and when Bourdain's turn came he searched for words to describe his attraction to heroin. "It's like something was missing in me," he said, "whether it was a self-image situation, whether it was a character flaw. There was some dark genie inside me that I very much hesitate to call a disease that led me to dope."

A dark genie: I liked the metaphor. I am a physician, yet I, too, am hesitant to call addiction a disease. While I am not the only skeptic in my field, I am certainly outnumbered by doctors, addiction professionals, treatment advocates, and researchers who do consider addiction a disease. Some go an extra step, calling addiction a *brain* disease. In my view, that is a step too far, confining addiction to the biological realm when we know how sprawling a phenomenon it truly is. I was reminded of the

shortcomings of medicalizing addiction soon after I arrived in Ironton, Ohio where, as the only psychiatrist in town, I was asked whether I thought addiction was "really a disease.

In September 2018, I set out for Rust Belt Appalachia from Washington, D.C., where I am a scholar at a think tank and was, at the time, a part-time psychiatrist at a local methadone clinic. My plan was to spend a year as a doctor-within-borders in Ironton, Ohio, a town of almost eleven thousand people in an area hit hard by the opioid crisis. Ironton sits at the southernmost tip of the state, where the Ohio River forks to create a tri-state hub that includes Ashland, Kentucky and Huntington, West Virginia. Huntington drew national attention in August 2016, when twenty-eight people overdosed on opioids within four hours, two of them fatally.

I landed in Ironton, the seat of Lawrence County, by luck. For some time I had hoped to work in a medically underserved area in Appalachia. Although I felt I had a grasp on urban opioid addiction from my many years of work in methadone clinics in Washington DC, I was less informed about the rural areas. So I asked a colleague with extensive Ohio connections to present my offer of clinical assistance to local leaders. The first taker was the director of the Ironton-Lawrence County Community Action Organization, or CAO, an agency whose roots extend to President Johnson's War on Poverty. The CAO operated several health clinics.

Ironton has a glorious past. Every grandparent in town remembers hearing first-person accounts of a period, stretching from before the Civil War to the early turn of the century, when Ironton was one of the nation's largest producers of pig iron. "For more than a century, the sun over Ironton warred for its place in the sky with ashy charcoal smoke," according to the *Ironton Tribune*. "In its heyday in the mid-nineteenth century there were forty-five [iron] furnaces belching out heat, filth, and prosperity for Lawrence County." After World War II, Ironton was a thriving producer of iron castings, molds used mainly by automakers. Other plants pumped out aluminum, chemicals, and fertilizer. The river front was a forest of smokestacks. High school graduates were assured good paying if labor-intensive jobs, and most mothers stayed home with the kids. The middle class was vibrant.

But then the economy began to realign. Two major Ironton employers, Allied Signal and Alpha Portland Cement, closed facilities in the late 1960s, beginning a wave of lay-offs and plant closings. The 1970s were a time of oil shocks emanating from turmoil in the Middle East. Inflation was high and Japanese and German car makers waged fierce competition with American manufacturers. As more Ironton companies downsized and then disappeared, the pool of living wage jobs contracted, and skilled workers moved out to seek work elsewhere. At the same time, the social fabric began to unravel. Domestic order broke down, welfare and disability rolls grew, substance use escalated. Most high school kids with a shot at a future pursued it elsewhere, and the place was left with a population dominated by older folks and younger addicts.

Ironton continues to struggle. Drug use, now virtually normalized, is in its third, sometimes fourth, generation. Almost everyone is at least one degree of separation away from someone who has overdosed. Although precise rates of drug involvement are hard to come by, one quarter to one third is by far the most common answer I hear when I ask sources for their best estimate of people dealing with a "drug problem of

any kind." Alluding to the paucity of hope and opportunity, one of my patients told me that "you have to eradicate the want — why people want to use — or you will always have drug problems."

When Pam Monceaux, an employment coordinator in town, asked me whether I thought addiction was "really a disease," she was thinking about her own daughter. Christal Monceaux grew up in New Orleans with her middle-class parents and a younger sister, and started using heroin and cocaine when she was nineteen. Pam blamed the boyfriend. "Brad sucked her in. Finally, she dumped him, went to rehab and did well, but a few months later took him back and the cycle began all over again." Eventually Christal's younger sister, who had moved to Nashville with her husband, persuaded her to leave New Orleans and join them. Pam, a serene woman who had over a decade's time to put her daughter's ordeal into perspective, said that relocating — or the "geographic cure," as it is sometimes called — worked for Christal. A new setting and new friends allowed her to relinquish drugs. She got married, had children, and lived in a $400,000 house. The happy ending was cut short by Christal's death at the age of forty-two of a heart attack. "If she could kick it for good when she was away from Brad and then when she moved to Nashville, how is that a disease?" Pam asked in her soft Louisiana drawl. "If I had breast cancer, I'd have it in New Orleans and in Nashville."

Unlike Christal, Ann Anderson's daughter had not left drugs behind for good. So, at age 66, Ann and her husband were raising their granddaughter, Jenna. Ann, who worked for my landlord, was bubbly, energetic, and, curiously, sounded as if she were raised in the deep South. The welcome basket she put together for me when I arrived, full of dish towels, potholders, and candies, foretold the generosity that she would show me

all year. Ann makes it to every one of Jenna's basketball games. Jenna's mom lives in Missouri and has been on and off heroin for years. "I love my daughter, but every time she relapsed, she made a decision to do it," said Ann, matter-of-factly, but not without sympathy. "And each time she got clean she decided that too."

Another colleague, Lisa Wilhelm, formed her opinions about addiction based on her experience with patients. Lisa was a seen-it-all nurse with whom I had worked at the Family Medical Center located across highway 52 from the Country Hearth, a drug den that passed itself off as a motel. She did not ask for my opinion about addiction; she told me hers. "I think it is a choice. And I'll devote myself to anyone who made that choice and now wants to make better ones," Lisa said, "But it's not a disease, I don't think."

Then there was Sharon Daniels, the director of Head Start. Sharon managed programs for drug-using mothers of newborns and toddlers. "I see opportunities our women have to make a different choice," she said. She is not pushing a naive "just say no" agenda, nor is she looking for an excuse to purge addicted moms from the rolls. This trim grandmother with bright blue eyes and year-round Christmas lights in a corner of her office is wholly devoted to helping her clients and their babies. But she thinks that the term disease "ignores too much about the real world of addiction. If we call it a disease, then it takes away from their need to learn from it."

Before coming to Ironton, I had never been asked what I thought about addiction by the counselors at the methadone clinic at which I worked in Washington. I am not sure why. Perhaps abstractions are not relevant when you are busy helping patients make step-wise improvements. Maybe the staff already knew what I would say. On those rare occasions

when a student or a non-medical colleague asked me, generally *sotto voce,* if addiction were *really* a disease my response was this: "Well, what are my choices?" If the alternatives to the disease label were "criminal act," "sin," or "moral deprivation," then I had little choice but to say that addiction was a disease. So, if a crusty old sheriff looking to justify his punitive lock-'em-up ways asked me if addiction were a disease, I would say, "Why yes, sir, it is."

But Pam, Beckey, Lisa, and Sharon had no concealed motives. They were genuinely interested in the question of addiction. And they were fed up with the false choice routinely thrust upon them in state-sponsored addiction workshops and trainings: either endorse addicts as sick people in need of care or as bad actors deserving of punishment. With such ground rules, no one can have a good faith conversation about addiction. Between the poles of diseased and depraved is an expansive middle ground of experience and wisdom that can help explain why millions use opioids to excess and why their problem can be so difficult to treat. The opioid epidemic's dark gift may be that it compels us to become more perceptive about why there is an epidemic. The first step is understanding addiction.

Most people know addiction when they see it. Those in its grip pursue drugs despite the damage done to their wellbeing and often to the lives of others. Users claim, with all sincerity, that they are unable to stop. This is true enough. Yet these accounts tell us little about what drives addiction, about its animating causal core — and the answer to those questions has been contested for over a century. In the mid-1980s the Harvard psychologist Howard J. Shaffer proclaimed that the field of addiction has been in a century-long state of "conceptual chaos." And not much has changed. For behaviorists, addiction is a "disorder of choice" wherein users weigh benefits against risks and eventually quit when the ratio shifts toward the side of risk. For some philosophers, it is a "disorder of appetite." Psychologists of a certain theoretical stripe regard it as a "developmental" problem reflecting failures of maturity, including poor self-control, an inability to delay gratification, and an absence of a stable sense of self. Sociologists emphasize the influence of peers, the draw of marginal groups and identification with them, and responses to poverty or alienation. Psychotherapists stress the user's attempt at "self-medication" to allay the pain of traumatic memories, depression, rage, and so on. The American Society of Addiction Medicine calls addiction "a primary, chronic disease of brain reward, motivation, memory and related circuitry." For the formerly addicted neuroscientist Marc Lewis, author of *Memoirs of an Addicted Brain,* addiction is a "disorder of learning," a powerful habit governed by anticipation, focused attention, and behavior, "much like falling in love."

None of these explanations best captures addiction, but together they enforce a very important truth. Addiction is powered by multiple intersecting causes — biological, psychological, social, and cultural. Depending upon the individual, the influence of one or more of these dimensions may be more or less potent. Why, then, look for a single cause for a complicated problem, or prefer one cause above all the others? At every one of those levels, we can find causal elements that contribute to excessive and repeated drug use, as well as to strategies that can help bring the behavior under control. Yet today the "brain disease" model is the dominant interpretation of addiction.

I happened to have been present at a key moment in the branding of addiction as a brain disease. The venue was the second annual "Constituent Conference" convened in the fall of 1995 by the National Institute on Drug Abuse, or NIDA, which is part of the National Institutes of Health. More than one hundred substance-abuse experts and federal grant recipients had gathered in Chantilly, Virginia for updates and discussions on drug research and treatment. A big item on the agenda set by the NIDA's director, Alan Leshner, was whether the assembled group thought the agency should declare drug addiction a disease of the brain. Most people in the room — all of whom, incidentally, relied heavily on NIDA-funding for their professional survival — said yes. Two years later Leshner officially introduced the concept in the journal: "That addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease."

Since then, NIDA's concept of addiction as a brain disease has penetrated the far reaches of the addiction universe. The model is a staple of medical school education and drug counselor training and even figures in the anti-drug lectures given to high-school students. Rehab patients learn that they have a chronic brain disease. Drug czars under Presidents Bill Clinton, George W. Bush, and Barack Obama have all endorsed the brain-disease framework at one time or another. From being featured in a major documentary on HBO, on talk shows and *Law and Order*, and on the covers of *Time* and *Newsweek*, the brain-disease model has become dogma — and like all articles of faith, it is typically believed without question.

Writing in the *New England Journal of Medicine* in 2016, a trio of NIH- and NIDA-funded scientists speculated that the "brain disease model continues to be questioned" because the science is still incomplete — or, as they put it, because "the aberrant, impulsive, and compulsive behaviors that are characteristic of addiction have not been clearly tied to neurobiology." Alas, no. Unclear linkages between actions and neurobiology have nothing to do with it. Tightening those linkages will certainly be welcome scientific progress — but it will not make addiction a brain disease. After all, if explaining how addiction operates at the level of neurons and brain circuits is enough to make addiction a brain disease, then it is arguably many other things, too: a personality disease, a motivational disease, a social disease, and so on. The brain is bathed in culture and circumstance. And so I ask again: why promote one level of analysis above all of the others?

Of course, those brain changes are real. How could they not be? Brain changes accompany any experience. The simple act of reading this sentence has already induced changes in your brain. Heroin, cocaine, alcohol, and other substances alter neural circuits, particularly those that mediate pleasure, motivation, memory, inhibition, and planning. But the crucial question regarding addiction is not whether brain changes take place. It is whether those brain changes obliterate the capacity to make decisions. The answer to that question is no. People who are addicted can respond to carrots and sticks, incentives and sanctions. They have the capacity to make different decisions when the stakes change. There is a great deal of evidence to substantiate faith in the agency of addicts. Acknowledging it is not tantamount to blaming the victim; it is, much more positively, a recognition of their potential.

The brain-disease model diverts attention from these

truths. It implies that neurobiology is necessarily the most important and useful level of analysis for understanding and treating addiction. Drugs "hijack" the reward system in the brain, and the patient is the hostage. According to the psychiatrist and neuroscientist Nora Volkow, who is currently the head of NIDA, "a person's brain is no longer able to produce something needed for our functioning and that healthy people take for granted, *free will*." Addiction disrupts the function of the frontal cortex, which functions as "the brakes," she told a radio audience, so that "even if I choose to stop, I am not going to be able to." Volkow deploys Technicolor brain scans to bolster claims of hijacked and brakeless brains.

Rhetorically, the scans make her point. Scientifically, they do not. Instead they generate a sense of "neuro-realism" — a term coined by Eric Racine, a bioethicist at the Montreal Clinical Research Institute, to describe the powerful intuition that brain-based information is somehow more genuine or valid than is non-brain-based information. In truth, however, there are limits to what we can infer from scans. They do not allow us, for example, to distinguish irresistible impulses from those that were not resisted, at least not at this stage of the technology. Indeed, if neurobiology is so fateful, how does any addict ever quit? Is it helpful to tell a struggling person that she has no hope of putting on the brakes? It may indeed seem hopeless to the person caught in the vortex of use, but then our job as clinicians is to make quitting and sustained recovery seem both desirable and achievable to them.

We start doing this in small ways, by taking advantage of the fact that even the subjective experience of addiction is malleable. As Jon Elster points out in *Strong Feelings: Emotions, Addiction, and Human Behavior*, the craving for a drug can be triggered by the mere belief that it is available. An urge

becomes overpowering when a person believes it is irrepressible. Accordingly, cognitive behavioral therapy is designed precisely to help people understand how to manipulate their environment and their beliefs to serve their interests. They may learn to insulate themselves from people, places, and circumstances associated with drug use; to identify emotional states associated with longing for drugs and to divert attention from the craving when it occurs. These are exercises in stabilization. Sometimes they are fortified with anti-addiction medications. Only when stabilized can patients embark on the ambitious journey of rebuilding themselves, their relationships, and their futures.

I have criticized the brain disease model in practically every lecture I have given on this wrenching subject. I have been relentless, I admit. I tell fellow addiction professionals and trainees that medicalization encourages unwarranted optimism regarding pharmaceutical cures and oversells the need for professional help. I explain that we err in calling addiction a "chronic" condition when it typically remits in early adulthood. I emphasize to colleagues who spend their professional lives working with lab rats and caged monkeys that the brain-disease story gives short shrift to the reality that substances serve a purpose in the lives of humans. And I proselytize that the brain changes induced by alcohol and drugs, no matter how meticulously scientists have mapped their starry neurons and sweeping fibers, need not spell destiny for the user.

Yet despite my strong aversion to characterizing addiction as a problem caused primarily by brain dysfunction, I genuinely appreciate the good ends that the proponents of the brain model have sought to reach. They hoped that "brain disease," with its intimation of medical gravitas and neurosci-

entific determinism, would defuse accusations of flawed character or weak will. By moving addiction into the medical realm, they can get it out of the punitive realm. And if addicts are understood to suffer from a brain disease, their plight will more likely garner government and public sympathy than if they were seen as people simply behaving badly. But would they? Research consistently shows that depictions of behavioral problems as biological, genetic, or "brain" problems actually elicit greater desire for social distance from afflicted individuals and stoke pessimism about the effectiveness of treatment among the public and addicted individuals themselves.

Evidence suggests that addicted individuals are less likely to recover if they believe that they suffer from a chronic disease, rather than from an unhealthy habit. More radically, there is a grounded argument to be made for feelings of shame, despite its bad reputation in therapeutic circles. "Shame is highly motivating," observes the philosopher Owen Flanagan, who once struggled mightily with alcohol and cocaine, "it expresses the verdict that one is living in a way that fails one's own survey as well as that of the community upon whose judgment self-respect is legitimately based." But under what conditions do feelings of shame end up prodding people into correcting their course, as opposed to making matters worse by fueling continued consumption to mute the pain of shameful feelings? The psychologists Colin Leach and Atilla Cidam uncovered a plausible answer. They conducted a massive review of studies on shame (not linked to addiction per se) and approaches to failure, and found that when people perceive that damage is manageable and even reversible shame can act as a spur to amend self-inflicted damage. They underscored what clinicians have long-known: only when

patients are helped to feel competent — "self-efficacious" is the technical term — can they begin to create new worlds for themselves.

Thinking critically about the disease idea is important for conceptual clarity. But a clinician must be pragmatic, and if a patient wants to think of addiction as a disease I do not try to persuade them otherwise. Yet I do ask one thing of them: to be realistic about the *kind* of disease it is. Despite popular rhetoric, addiction is not a "disease like any other." It differs in at least two important ways. First, individuals suffering from addiction respond to foreseeable consequences while individuals with conventional diseases cannot. Second, this "disease" is driven by a powerful emotional logic.

In 1988, Michael Botticelli, who would go on to become President Obama's second drug czar over two decades later, was charged with drunk driving on the Massachusetts Turnpike. A judge gave him the choice of going to jail or participating in a treatment program. Botticelli made a decision: he went to a church basement for help, joined Alcoholics Anonymous, and quit drinking. Yet on CBS' *60 Minutes* he contradicted his own story when he drew an analogy between having cancer and being addicted. "We don't expect people with cancer to stop having cancer," he said. But the analogy is flawed. No amount of reward or punishment, technically called "contingency," can alter the course of cancer. Imagine threatening to impose a penalty on a brain cancer victim if her vision or speech continued to worsen, or to offer a million dollars if she could stay well. It would have no impact and it would be cruel. Or consider Alzheimer's, which is a true brain disease.

(True insofar as the pathology originates in derangements of brain structure and physiology.) If one held a gun to the head of a person addicted to alcohol and threatened to shoot her if she consumed another drink, or offered her a million dollars if she desisted, she could comply with this demand — and the odds are high that she would comply. In contrast, threatening to shoot an Alzheimer's victim if her memory further deteriorated (or promising a reward if it improved) would be pointless.

The classic example of the power of contingency is the experience of American soldiers in Vietnam. In the early 1970s, military physicians in Vietnam estimated that between 10 percent and 25 percent of enlisted Army men were addicted to the high-grade heroin and opium of Southeast Asia. Deaths from overdosing soared. Spurred by fears that newly discharged veterans would ignite an outbreak of heroin use in American cities, President Richard Nixon commanded the military to begin drug testing. In June 1971, the White House announced that no soldier would be allowed to board a plane home unless he passed a urine test. Those who failed could go to an Army-sponsored detoxification program before they were re-tested.

The plan worked. Most GIs stopped using narcotics as word of the new directive spread, and most of the minority who were initially prevented from going home produced clean samples when given a second chance. Only 12 percent of the soldiers who were dependent on opiate narcotics in Vietnam became re-addicted to heroin at some point in the three years after their return to the United States. Whereas heroin helped soldiers endure wartime's alternating bouts of boredom and terror, most were safe once they were stateside. At home, they had different obligations and available rewards, such as their families, jobs, friends, sports, and hobbies. Many GIs needed heroin to cool the hot anger they felt at being sent to fight for the losing side by commanders they did not respect. Once home, their rage subsided to some extent. Also, heroin use was no longer normalized as it was overseas. At home, heroin possession was a crime and the drug was harder and more dangerous to obtain. As civilian life took precedence, the allure of heroin faded.

We know the value of "contingencies." Hundreds of studies attest to the power of carrots and sticks in shaping the behavior of addicted individuals. Carl Hart, a neuroscientist at Columbia University, has shown that when people are given a good enough reason to refuse drugs, such as cash, they respond. He ran the following experiment: he recruited addicted individuals who had no particular interest in quitting, but who were willing to stay in a hospital research ward for two weeks for testing. Each day Hart offered them a sample dose of either crack cocaine or methamphetamine, depending upon the drug they use regularly. Later in the day, the subjects were given a choice between the same amount of drugs, a voucher for $5 of store merchandise, or $5 cash. They collected their reward upon discharge two weeks later. The majority of subjects choose the $5 voucher or cash when offered small doses of the drug, but they chose the drug when they were offered a higher dose. Then Hart increased the value of the reward to $20, and his subjects chose the money every time.

One of my patients, I will call her Samantha, had been using OxyContin since 2011 when she was working in the kitchen at Little Caesar's in downtown Ironton. The 20 mg pills belonged to her grandmother, whose breast cancer had spread to her spine. Samantha visited her grandma after work, watched TV

with her, and went through the mail. She would also remove three or four pills per day from the massive bottle kept by the fancy hospital bed that Samantha's brother moved into the living room. When Samantha's grandmother died in 2016, so did the pill supply. "I just couldn't bring myself to do heroin, and, anyway, I had no money for drugs," Samantha said.

When the pills were almost gone, Samantha drove to an old friend's house, hoping that the friend would give her a few Oxy's in exchange for walking Snappy, her arthritic chihuahua. "My friend wasn't home, but her creepy boyfriend Dave answered the door and told me he'd give me some Oxy's if I gave him a blow job." Samantha was feeling the warning signs of withdrawal — jitteriness, crampy stomach, sweaty underarms. Desperate to avoid full blown withdrawal, she gave a minute's thought to the proposition. "Then I felt revolted and I said no way and drove straight here because I knew I could start buprenorphine the same day," she said.

What of Samantha's "hijacked" brain? When she stood before Dave, her brain was on fire. Her neurons were screaming for oxycodone. Yet in the midst of this neurochemical storm, at peak obsession with drugs, Samantha's revulsion broke through, leading her to apply the "brakes" and come to our program. None of this means that giving up drugs is easy. But it does mean that an "addicted brain" is capable of making a decision to quit and of acting on it.

On Tuesday nights, I co-ran group therapy with a wise social worker named John Hurley. In one group session, spurred by a patient sharing that he decided to come to treatment after spending some time in jail, the patients went around the room reciting what brought them to the clinic. Without exception, they said that they felt pressured by forces inside or outside themselves.

"I couldn't stand myself."
"My wife was going to leave me."
"My kids were taken away."
"My boss is giving me one more chance."
"I can't bear to keep letting my kids down."
"I got Hep C."
"I didn't want to violate my probation."

Ultimatums of these kinds were often the best things to happen to our patients. For other addicts, the looming consequences proved so powerful that they were able to quit without any professional help at all.

The psychologist Gene Heyman at Boston College found that most people addicted to illegal drugs stopped using by about age thirty. John F. Kelly's team at Massachusetts General Hospital found that forty-six percent of people grappling with drugs and alcohol had resolved their drug problems on their own. Carlos Blanco and his colleagues at Columbia University used a major national database to examine trends in prescription drug problems. Almost all individuals who abused or were addicted to prescription opioids also, at some point in their lives, had a mental disorder, an alcohol or drug problem, or both. Yet roughly half of them were in remission five years later. Given low rates of drug treatment, it is safe to say that the majority of remissions took place without professional help.

These findings may seem surprising to, of all people, medical professionals. Yet it is well-known to medical sociologists that physicians tend to succumb to the "clinicians' illusion," a habit of generalizing from the sickest subset of patients to the overall population of people with a diagnosable condition. This caveat applies across the medical spectrum. Not all people with diabetes, for example, have brittle blood sugars — but they will represent a disproportionate share of

the endocrinologist's case load. A clinician might wrongly, if rationally, assume that most addicts behave like the recalcitrant ones who keep stumbling through the emergency room doors. Most do not. Granted, not everyone can stop an addiction on their own, but the very fact it can be done underscores the reality of improvement powered by will alone: a pathway to recovery rarely available to those with conventional illness.

The second major difference between addiction and garden-variety disease is that addiction is driven by powerful feelings. Ask an alcoholic why she drinks or an addict why he uses drugs and you might hear about the pacifying effect of whisky and heroin on daunting hardship, unremitting self-persecution, yawning emptiness, or harrowing memories. Ask a patient with Parkinson's disease, a classic brain disease, why he developed the neurological disorder and you will get a blank stare. Parkinson's is a condition that strikes, unbidden, at the central nervous system; the patient does not consciously collude in bringing it about. Excessive use of a drug, by contrast, serves some kind of need, an inner pain to be soothed, a rage to be suppressed. It is a response to some sort of suffering.

Memoirs offer portals into the drama of addiction. One of my favorites is *Straight Life,* by the master alto saxophonist Art Pepper. Self-taught on the instrument by the age of thirteen, Pepper endured a childhood of psychological brutality at the hands of a sadistic alcoholic father, an icicle of a grandmother, and an alcoholic mother who was fourteen years old when he was born and who did not hide her numerous attempts to abort him. "To no avail," he writes. "I was born. She lost."

What preoccupied him as a child was "wanting to be loved and trying to figure out why other people were loved and I wasn't." Pepper's self-loathing bubbled like acid in his veins. "I'd talk to myself and say how rotten I was," he wrote. "Why do people hate you? Why are you alone?" At 23, after years of alcohol and pot, he sniffed his first line of heroin through a rolled up dollar-bill and the dark genie dissolved. He saw himself in the mirror. "I looked like an angel," he marveled. "It was like looking into a whole universe of joy and happiness and contentment."

From that moment on, Pepper said, he would "trade misery for total happiness... I would be a junkie...I will die a junkie." Indeed, he became a "lifelong dope addict of truly Satanic fuck-it-all grandeur," in the words of his passionate admirer, the critic and scholar Terry Castle. He was in and out of prison for possession charges. Pepper lived without heroin for a number of years after attending Synanon, a drug-rehabilitation center in California, from 1969 to 1972 and was treated with methadone for a period in the mid-1970s. Eventually, though, he returned to drugs, mainly consuming massive amphetamine, and died from a stroke in 1982. He was 56.

Addicts can appear to have everything: a good education, job prospects, people who love them, a nice home. They can be people who "are believed to have known no poverty except that of their own life-force," to borrow the words of Joan Didion, and yet suffer greatly. The malaise is internal. Or they can be in dire circumstances, immiserated by their lives, moving through a dense miasma. "There was nothing for me here," said one patient whose child was killed in a car accident, whose husband cheated on her, and who was trapped in her job as a maid in a rundown motel with an abusive boss. OxyContin made her "not care." She reminded me of Lou Reed's song "Heroin":

Wow, that heroin is in my blood
And the blood is in my head
Yeah, thank God that I'm good as dead
Oooh, thank your God that I'm not aware
And thank God that I just don't care

Pharmacologists have long classified opioid drugs as euphoriants, inducers of pleasure, described often as a feeling of a melting maternal embrace, but they could just as easily be called obliviants. According to the late Harvard psychiatrist Norman Zinberg, oblivion seekers yearned "to escape from lives that seem unbearable and hopeless." Thomas De Quincey, in *Confessions of an English Opium Eater*, which appeared in 1821, praised opium for keeping him "aloof from the uproar of life." Many centuries before him Homer had likely referred to it in the *Odyssey* when he wrote that "no one who drank it deeply…could let a tear roll down his cheeks that day, not even if his mother should die, his father die, not even if right before his eyes some enemy brought down a brother or darling son with a sharp bronze blade," When the Hollywood screenwriter Jerry Stahl surveyed his life in 1995 in his memoir *Permanent Midnight*, he concluded that "everything, bad or good, boils back to the decade on the needle, and the years before that imbibing everything from cocaine to Romilar, pot to percs, LSD to liquid meth and a pharmacy in between: a lifetime spent altering the single niggling fact that to be alive means being conscious." Drugs helped him to attain "the soothing hiss of oblivion."

According to ancient myth, Morpheus, the god of dreams, slept in a cave strewn with poppy seeds. Through the cave flowed the river Lethe, known as the river of forgetfulness, also called the river of oblivion. The dead imbibed those waters to forget their mortal days. Unencumbered by memory, they floated free from the aching sadness and discomforts of life. The mythological dead share a kinship with opioid addicts, oblivion-seekers, and all their reality-manipulating cousins. The difference, mercifully, is that actual people can "un-drink" the numbing waters. *Aletheia*, truth, is a negation of *lethe*, the Greek word for forgetting. Recovery from addiction is a kind of unforgetting, an attempt to live in greater awareness and purpose, a disavowal of oblivion.

Addiction is a cruel paradox. What starts out making life more tolerable can eventually make it ruinous. "A man may take to drink because he feels himself a failure," said Orwell, "but then fail all the more completely because he drinks." The balm is a poison. Drugs that ease the pain also end up prolonging it, bringing new excruciations — guilt and grief over damage to one's self, one's family, one's future — and thus fresh reason to continue. The cycle of use keeps turning. Ambivalence is thus a hallmark of late-stage addiction. The philosopher Harry Frankfurt speaks of the "unwilling addict" who finds himself "hating" his addiction and "struggling desperately…against its thrust." This desperate struggle is what Samuel Taylor Coleridge, himself an opium addict, called "a species of madness" in which the user is torn between his current, anguished self who seeks instant solace and a future self who longs for emancipation from drugs. This explains why the odds of treatment drop out are high — over half after six months, on average. The syringe of Damocles, as Jerry Stahl described the vulnerability to relapse, dangles always above their heads. Many do not even take advantage of treatment when it is offered, reluctant to give up their short-term salvation. They fear facing life "unmedicated" or cannot seem to find a reason for doing so. My friend Zach Rhoads, now a

teacher in Burlington, Vermont, used heroin for five years beginning in his early twenties and struggled fiercely to quit. "I had to convince myself that such effort was worth the trouble," he said.

Thomas De Quincey consumed prodigious amounts of opium dissolved in alcohol and pronounced the drug a "panacea for all human woes." For Anthony Bourdain, heroin and cocaine were panaceas, defenses against the dark genie that eventually rose up and strangled him to death in 2018. But not all addicts have a dark genie lurking inside them. Some seek a panacea for problems that crush them from the outside, tribulations of financial woes and family strain, crises of faith and purpose. In the modern opioid ordeal, these are Americans "dying of a broken heart," in Bill Clinton's fine words. "They're the people that were raised to believe the American Dream would be theirs if they worked hard and their children will have a chance to do better — and their dreams were dashed disproportionally to the population as the whole." He was gesturing toward whites between the ages of 45 and 54 who lack college degrees — a cohort whose life-expectancy at birth had been falling since 1999. They succumbed to "deaths of despair," a term coined by the economists Anne Case and Angus Deaton in 2015, brought on by suicide, alcoholism (specifically, liver disease), and drug overdoses. Overdoses account for the lion's share. The white working class has been undermined by falling wages and the loss of good jobs which have "devastated the white working class," the economists write, and "weakened the basic institutions of working-class life, including marriage, churchgoing, and community."

Looking far into the future, what so many of these low income, under-educated whites see are dark horizons. When communal conditions are dire and drugs are easy to get, epidemics can blossom. I call this dark horizon addiction. Just as dark genie addiction is a symptom of an embattled soul, dark horizon addiction reflects communities or other concentrations of people whose prospects are dim and whose members feel doomed. In Ironton, clouds started to gather on the horizon in the late 1960s. Cracks appeared in the town's economic foundation, setting off its slow but steady collapse.

Epidemics of dark horizon addiction have appeared under all earthly skies at one time or another. The London gin "craze" of the first half of the eighteenth century, for example, was linked to poverty, social unrest, and over-crowding. According to the historian Jessica Warner, the average adult in 1700 drank slightly more than a third of a gallon of cheap spirits over the course of a year; by 1729 it was slightly more than 1.3 gallons per capita, and hit 2.2 gallons in 1743. A century later, consumption had declined, yet gin was still "a great vice in England," according to Charles Dickens. "Until you improve the homes of the poor, or persuade a half-famished wretch not to seek relief in the temporary oblivion of his own misery," he wrote in the 1830s, "gin-shops will increase in number and splendor."

During and after the American Civil War, thousands of men needed morphine and opium to bear the agony of physical wounds. In his *Medical Essays*, the physician Oliver Wendell Holmes, Sr., a harsh critic of medication, excepted opium as the one medicine "which the Creator himself seems to prescribe." The applications of opium extended to medicating grief. "Anguished and hopeless wives and mothers, made so by the slaughter of those who were dearest to them, have found, many of them, temporary relief from their suffer-

ings in opium," Horace B. Day, an opium addict himself, recorded in *The Opium Habit* in 1868. In the South, the spiritual dislocation was especially profound, no doubt explaining, to a significant degree, why whites in the postbellum South had higher rates of opiate addiction than did those in the North — and also, notably, one reason why southern blacks had a lower rate of opiate addiction, according to the historian David T. Courtwright. "Confederate defeat was for most of them an occasion of rejoicing rather than profound depression."

A similar dynamic was seen when Russia's long-standing problem with vodka exploded during the political instability and economic uncertainty of the post-Communist era. The majority of men drank up to five bottles a week in the early 1990s. Back home, heroin was a symptom of ghetto life for millions of impoverished and hopeless Hispanics and blacks in the 1960s and 70s, followed by crack among blacks in the mid-80s. The rapid decline of manufacturing jobs for inner city men, writes the historian David Farber in his recent book *Crack*, "helps explain the large market of poor people, disproportionately African Americans, who would find crack a balm for their troubled, insecure, and often desperate lives."

Children raised by dark horizon parents often bear a double burden. Not only do they suffer from growing up with defeated people in defeated places where opportunities are stunted and boredom is crushing. Often they are casualties of their parents' and their grandparents' addictions. One of my patients, Jennifer, described herself as a "third generation junky." Patches of acne clung to her cheeks, making her look younger than thirty. Her maternal grandmother managed well enough with an ornery husband who drank too much on weekends until he lost his job at a local casting plant in the 1970s and became a full-fledged alcoholic, bitter, aimless, and abusive to his wife. The grandmother worked cleaning motel rooms and began staying out late, using pills and weed. Jennifer's mother, Ann, was the youngest in a household that had devolved into havoc.

When Ann was sixteen, Jennifer was born. Not one reliable adult was around. "No one really cared if I went to school," Jennifer recalls. No one urged her to succeed or expressed confidence in her. "I learned that when something bothered you, you got high." Her mother, Ann, was aloof, Jennifer said, except for the stretch they were both in jail at the same time: she was 19, her mother was 42. "My mother was assigned to be the chaperone for my group of inmates," Jennifer recalled. "She did my laundry and saved me extra food in jail. It was the only time she acted like a mom towards me." Children raised in such homes are greatly disadvantaged. The absence of a steady protector in their lives often derails their developing capacity for tolerating frustration and disappointment, controlling impulses, and delaying gratification. They have difficulty trusting others, forming rewarding connections with others and they often see themselves as damaged and worthless. When adults around them do not want to work regularly, children cannot imbibe the habits of routine, reliability, and dependability. At worst, the cycle repeats itself, inflicting wounds across generations and communities as their collective disenchantment with the future mounts. Sociologists call this "downward social drift."

The germ theory of addiction: that is my term for one of the popular if misbegotten narratives of how the opioid crisis started. It holds that the epidemic has been driven almost

entirely by supply — a surfeit not of bacteria or viruses, but of pills. "Ask your doctor how prescription pills can lead to heroin abuse," blared massive billboards from the Partnership for a Drug-Free New Jersey that I saw a few years ago. Around that time, senators proposed a bill that would have limited physician prescribing. "Opioid addiction and abuse is commonly happening to those being treated for acute pain, such as a broken bone or wisdom tooth extraction," is how they justified the legislation.

Not so. The majority of prescription pill casualties were never patients in pain who had been prescribed medication by their physicians. Instead, they were mostly individuals who were already involved with drugs or alcohol. Yes, some actual patients did develop pill problems, but generally they had a history of drug or alcohol abuse or were suffering from concurrent psychiatric problems or emotional distress. It is also true, of course, that drug marketers were too aggressive at times and that too many physicians overprescribed, sometimes out of inexperience, other times out of convenience, and in some cases out of greed.

As extra pills began accumulating in rivulets, merging with pills obtained from pharmacy robberies, doctor shopping, and prescription forgeries, a river of analgesia ran through various communities. But even with an ample supply, you cannot "catch" addiction. There must be demand — not for addiction, per se, but for its vehicle. My year in Ironton showed me that the deep story of drug epidemics goes well beyond public health and medicine. Those disciplines, while essential to management, will not help us to understand why particular people and places succumb. It is the life stories of individuals and, in the case of epidemics, the life story of places, that reveal the origins. Addiction is a variety of human experience, and it must be studied with all the many methods and approaches with we which we study human experience.

Dark genies can be exorcised and dark horizons can be brightened. It is arduous work, but unless we recognize all the reasons for its difficulty, unless we reckon with the ambiguity and the elusiveness and the multiplicity of addiction's causes, unless we come to understand why addicts go to such lengths to continue maiming themselves with drugs — compelled by dark genies, dark horizons, or both — their odds of lasting recovery are slim, as are the odds of preventing and reversing drug crises. The complexity of addiction is nothing other than the complexity of life.

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