Bibliography and Notes


Brandsma, J. (1979). *Outpatient Treatment of Alcoholism: A Review and Comparative Study*. University Park Press. Study divides three groups AA, Control group, Lay- R.B.T (Research based treatment) results: three months after termination of treatment, “In this analysis AA was five times more likely to binge than the control and Nine times more likely than the lay-R.B.T.”


"A federal court has ruled that adjudicating persons into Alcoholics Anonymous is violating their constitutional rights because the program is religious. The U.S. Court of Appeals for the Second Circuit ruled that an atheist drunk driver's constitutional rights were violated when he was forced, as a condition of probation, to participate in a "religion-tinged Alcoholics Anonymous program."


“Study compared D.W.I offenders in three groups, 1) no treatment, 2) alcoholism clinic, and 3) Alcoholics Anonymous. No treatment, 44% no re-arrests, 34% re-arrested after 1st month of “treatment”, 22% re-arrested within first month of “treatment”. Alcoholism clinic 32% no re-arrests, 47% re-arrested after 1st month of treatment, 21% re-arrested within first month of treatment. Alcoholics Anonymous 31% no re-arrests, 47% re-arrested after 1st month of treatment, 22% re-arrested within first month of treatment. Conclusion: “The failure of the alcoholism clinic and Alcoholics Anonymous to produce no recidivists than did no treatment at all ought to be of great concern.”

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<th>No re-arrests</th>
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<tr>
<td>No Treatment</td>
<td>44%</td>
<td>21%</td>
<td>34%</td>
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<tr>
<td>Alcoholism Clinic</td>
<td>32%</td>
<td>21%</td>
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<td>AA</td>
<td>31%</td>
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Accordingly and clearly, the best option for those on probation is “no treatment.”


Based on collectively more than 50 years first-hand experience in AA, the authors of the Jude Thaddeus Program * and the Jude Thaddeus Home Program*, agree that Rebecca Farnsway’s book is an accurate depiction of AA, which, in part, states: “One fair-minded 12-Stepper suggested that every new A.A. member should be issued copies of both the Big Book and this book when he or she walks in the door, to tell the newcomers about both the good and the bad things that could happen to them in “the rooms.” One of the most disturbing repeated themes is women who were the victims of rape or thirteenth-stepping [meaning approached by older members for sex] being told to just shut up and find their part in it and go make some coffee, and to not harbor any resentments against their attackers.” [However, Rebecca Fransway’s book stops short of defining all the dangers awaiting young men and women and new members entering AA. AA is a hunting ground for all sorts of sexual predators, financial predators, physically abusive predators and the like.]


“Any doubts about the relevance of the Vietnam veterans study are allayed by findings from long-term studies of drug users in the U.S. Long-term cocaine users, for example, generally do not become addicts. And when they do go through periods of abuse, they typically cut back or quit on their own. They may not do so as rapidly as others (and they themselves) wish they would. But addicts act very much like other human beings: They pursue pleasure or relief, and most will change their behavior when it causes them serious harm, so long as they have reasonable alternatives.” “According to the National Household Survey on Drug Abuse (overseen by the Substance Abuse and Mental Health Services Administration), about 3 million Americans have used heroin. Of these, one in 10 reports using the drug in the last year, and one in 20 say they’ve used it in the past month. The percentages for cocaine are similar. In both cases, daily use is so rare that the government does not provide figures for it. These findings indicate that the vast majority of heroin and cocaine users either never become addicted or, if they do, soon manage to moderate their use or abstain.”


“Simply Irresistible? Even if addiction is not a physical compulsion, perhaps some drug experiences are so alluring that people find it impossible to resist them. Certainly that is heroin's reputation, encapsulated in the title of a 1972 book: It's So Good, Don't Even Try It Once. The fact that heroin use is so rare-involving, according to the government’s data, something like 0.2 percent of the U.S. population in 2001--suggests that its appeal is much more limited than we've been led to believe. If heroin really is "so good," why does it have such a tiny share of the illegal drug market? Marijuana is more than 45 times as popular. The National Household Survey on Drug Abuse indicates that about 3 million Americans have used heroin in their lifetimes; of them, 15 percent had used it in the last year, 4 percent in the last month. These numbers suggest that the vast majority of heroin users either never become addicted or, if they do, manage to give the drug up. A
survey of high school seniors found that 1 percent had used heroin in the previous year, while 0.1 percent had used it on 20 or more days in the previous month. Assuming that daily use is a reasonable proxy for opiate addiction, one in 10 of the students who had taken heroin in the last year might have qualified as addicts. These are not the sort of numbers you'd expect for a drug that's irresistible.”


It is true that people can "crave" pizza as they might a cigarette, that they feel weak and shaky when calories (or heroin) "wear off" and that they sometimes consume fries (or cocaine) compulsively. But these facile comparisons tell us little about the nature of overeating. Instead, they show how the term "addiction" can be stretched until it becomes meaningless. Virtually every pleasure we encounter — listening to beautiful music, sex, even exercise — is associated with surges of dopamine similar to those during a high-fat meal. But we call these pleasures, not addictions. Scientists cannot look at dopamine levels or brain scans and tell the difference......Desire vs. action. When cocaine addicts, for example, are shown drug paraphernalia (a crack pipe or lines of white powder on a mirror,) they experience craving, and their pleasure centers (unsurprisingly) light up on PET scans, which capture images of brain activity. Those images, however, tell us little about whether the brain's owner is compelled to act on his desire. When researchers at Massachusetts General Hospital presented pictures of pretty women to heterosexual men, their pleasure centers also lit up brightly on PET scans, but the men did not rush out to have sex. Arizona State University psychologist William Uttal calls imaging technologies "the new phrenology" after the 19th-century practice of using bumps on the head to decipher a person's abilities and character. Today's brain-imaging techniques, while not quackery, rarely permit scientists to predict behavior, he says “I've seen recovering addicts and alcoholics fight their cravings through sheer willpower — even though, if we put them in PET scanners, we would doubtless find their brains lit up like Christmas trees. The word "addiction" is perilously close to losing any meaning. If lawyers can turn fast food into an addiction and pin liability on restaurants, it won't be long before adulterers sue Sports Illustrated, claiming its swimsuit issue led them astray.”


“Cognitive science is the interdisciplinary study of mind and intelligence, embracing philosophy, psychology, artificial intelligence, neuroscience, linguistics, and anthropology. Its intellectual origins are in the mid-1950s when researchers in several fields began to develop theories of mind based on complex representations and computational procedures. Its organizational origins are in the mid-1970s when the Cognitive Science Society was formed and the journal Cognitive Science began. Since then, more than sixty universities in North America, Europe, Asia, and Australia have established cognitive science programs, and many others have instituted courses in cognitive science.”


“It is impossible to identify any characteristic feature of either the symptomatology or the etiology of so-called mental illnesses which consistently distinguishes them from physical illnesses.” This assertion seems to go to the heart of Szasz’s insistence that mental illnesses are not real diseases. But rather than refute it, he replies, "This is true, but not enough." Enough for what isn't exactly clear. Szasz then cites three distinctions between physical and mental illness that are generally valid but do not hold in every case: 1) "Typically, physical illnesses are identified by observing the patient's body," while "typically, mental illnesses are identified by observing the patient's verbal pronouncements." 2) There are "objective, physical-chemical markers" to ascertain whether someone has a particular brain disease but "no such markers" to ascertain whether he has a particular mental illness. 3) "The typical medical patient" is treated only with his informed consent, while "the typical mental patient" is treated without his consent.” “Although that last claim does not apply to the millions of Americans who voluntarily seek antidepressants or psychotherapy as a way of improving their lives, it arguably describes hospitalized mental patients, keeping in mind the blurry line between voluntary and involuntary commitment. The combination of subjective diagnosis and involuntary treatment poses obvious dangers. As Szasz says, "There is no way that someone can disprove the 'diagnosis' that he 'suffers' from schizophrenia." (Or Addiction/Alcoholism for that matter) “…purports to draw a line between those who are morally responsible and those who are not, those who are blameworthy and those who are not, those who have free will and those who do not.” As Szasz notes in his reply, purport usually suggests a pretense of some sort.” “Given the sweep of the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM), which takes in misbehavior ranging from rudeness to murder, it's fair to read this caveat to mean that anything bad people think, feel, say, or do can be interpreted as a symptom of a disease. In practice, psychiatrists often distinguish between "severe" disorders thought to have a physiological basis and the myriad sins, foibles, bad habits, and eccentricities cataloged by the DSM. But their training, terminology, diagnostic framework, and billing practices imply that all these are medical problems appropriately handled by physicians. As Kendell notes, "the inexorable expansion of the concept of mental illness" despite a "fragile empirical basis" leaves psychiatrists "vulnerable to accusations of unjustified medicalization of deviant behavior and the vicissitudes of daily life." “That limitation should give Torrey pause in light of the concerns he expressed in his 1974 book The Death of Psychiatry, quoted in Szasz Under Fire. He argued that "it is better that we err on the side of labeling too few, rather than too many, as brain diseased. In other words, a person should be presumed not to have a brain disease until proven otherwise on the basis of probability. This is exactly the opposite of what we do now as we blithely label everyone who behaves a little oddly 'schizophrenic.' Human dignity rather demands that people be assumed to be in control of their behavior and not brain diseased unless there is strong evidence to the contrary."


“More than two thirds (70%) of those with long abstentions said that other persons did not continue to treat them as if they were addicts. Men who reported to the interviewers that they were treated like addicts during abstinence more often had perilous adjustments (as reflected in lower adjustment scores) and shorter periods of abstinence than those not treated like addicts. Half (50%) of all those who reported they were not treated like addicts had high adjustment scores, while only 17% of those treated like addicts had high scores. One third (33%) of those not treated like addicts had abstentions of 24 months or longer, while only one in six (16%) of those treated like addicts had similar long periods off heroin.”


“In general, we found six different patterns of recovery and with the discovery of so much variety have concluded that the, “Maturing out”, concept has only limited utility in describing the process or patterns of change. In addition to maturation, which we call developmental change, we found that some addicts: 1) become converts to religious, spiritual or ideological groups, 2) change their behavior when their environment changes, 3) retire from drug use but maintain some elements of the life-style, 4) become alcoholics or mentally ill, 5) simply drift into the mainstream.” What Waldorf failed to recognize is that all five of his identified developmental changes are, in fact, the “maturing out” process.