Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone number and e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor Designate, *Psychiatric Services*, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

The Disease Analogy and Substance Abuse

To the Editor: In the Alcohol & Drug Abuse column in the November 2003 issue, Drs. Marlowe and DeMatteo (1) objected to the use of the disease analogy to conceptualize and treat substance abuse and to formulate drug policy. They made the point that although antisocial behavior is not treated as a disease, the population distribution for it is much the same as it is for substance abuse, hypertension, and diabetes. In elegantly making their point, however, the authors seem to have missed the point.

The literature is clear that all these conditions—substance abuse, antisocial behavior, hypertension, and diabetes—have their roots in genetic vulnerability and that their behavioral expression is shaped physiologically by environmental influences and personal choices (2–4). Labeling these conditions diseases is not a form of forgiveness or a reprieve from responsibility. No one would contend that personal choices don't affect the course of both diabetes and bipolar illness. No one would deny that treatment adherence may not fully control an inexorable course in either condition (5). But what we do deny is that the substantial difference between what we call social disorders and what we call diseases is our lack of knowledge of when and how to effectively intervene in those so-called social disorders. And what we also deny is that the search for that knowledge has been severely impeded by false distinctions between physical and mental and between social and medical disorders.

Setting up false dichotomies does not protect us from poorly conceived policy. Drs. Marlowe and DeMatteo—and policy makers—would be better served by using the old child psychiatry model—"vulnerability, risk, adaptation"—to understand how and whether the policies they envision do, in fact, apply and will or will not work.

Marcia Scott, M.D.

Dr. Scott was formerly vice-president of medical services at Prudential Group Life and Disability and currently serves as a consultant to the City of Boston.

References

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2. Jacobson KC, Prescott CA, Kendler KS: Sex differences in the genetic and environmental influences on the development of antisocial behavior. Development and Psychopathology 91:395–416, 2002
3. Nestler EJ, Aghajanian GK: Molecular and cellular basis of addiction. Science 278: 58–53, 1997
4. Rutter M: Nature, nurture, and development: from evangelism through science toward policy and practice. Child Development 73:1–21, 2002
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In Reply: The thrust of our argument was that analogy is always an invalid form of logical or scientific reasoning, regardless of the substantive area. Not one of us can resist the temptation to selectively underscore those semblances that support our biases and ignore those that cause us discomfort. It is undoubtedly true that substance abuse, chronic medical illness, and antisocial behavior are all products of varying degrees of genetics, environment, and choice. Indeed, we would defy anyone to name a single complex human trait or condition that is not so influenced. But therein lies the problem. Because substance abuse is omnigenus (like everything else), we are all free to propose our own heuristic paradigm for the condition that fits our values. Dr. Scott is certainly free to choose a medical paradigm—"the old child psychiatry model"—for her practice and writings, but she offers no compelling reason why others must do the same.

Douglas B. Marlowe, J.D., Ph.D.
David S. DeMatteo, J.D., Ph.D.

Submissions for Datapoints Invited

Submissions to the journal's Datapoints column are invited. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. National data are preferred. The text ranges from 350 to 500 words, depending on the size and number of figures used. The text should include a short description of the research question, the database and methods, and any limitations of the study.

Inquiries or submissions should be directed to Harold Alan Pincus, M.D., or Terri L. Tanielian, M.S., editors of the column. Contact Ms. Tanielian at Rand, 1200 South Hayes Street, Arlington, Virginia 22202 (terri_tanielian @rand.org).