My name is Terry Gorski. I'm the President of the CENAPS Corporation, a training and consultation firm that specializes in chemical dependency and related behavioral health problems. I am pleased to have this opportunity to discuss with Dr. Marlatt the issue of whether Alcoholism does or does not meet the criteria of being a disease.

The way that we conceptualize alcoholism and other drug dependencies is critical to the development of effective policy for its treatment. Effective policy is necessary to secure the adequate resources needed for its treatment.

*If alcoholism is defined as a disease*, it will be treated as a healthcare problem. As a result, alcoholics will be assured the right to receive appropriate medical treatment for this disease. The treatment of Alcoholism will be covered by health insurance and other health care financing plans in both the public and private sectors. The appropriate health care groups will be mobilized to support its treatment. And, most importantly, ongoing biomedical research which relates alcoholism to other diseases will be funded.

*If alcoholism is not defined as a disease*, we will be making the decision that it does not rightfully belong within healthcare. Alcoholics, then, will be denied access to vital healthcare services. Insurance and other health care financing plans will exclude alcoholism. Alcoholism, which is responsible for 30% of all inpatient hospital days and nearly 50% of emergency room visits, will be divorced from the medical field. As a result it will never be fully integrated into our health care system.

*If Alcoholism is not a disease, then what is it and how should society deal with it?*

The answer to this question is vital. If alcoholism is not a disease, then it is not a healthcare problem. If it is not a healthcare problem then the healthcare system that is devoted to the prevention, early identification, and treatment of disease should not become involved with those afflicted with alcoholism. If this is the case, where should the alcoholic go to receive treatment?

To say that Alcoholism is an “addiction”, an “affliction”, or “an appetite habit disorder” is to avoid the key question: “Does Alcoholism meet the criteria of a disease?” If we call alcoholism by another name, we must still apply the same question. If we call it an *addiction*, we must ask the question “Does an addiction meet the criteria of a disease?” If we call it an *affliction*, we must ask the questions “Does an affliction meet the criteria of a disease?” If we call it an *appetite habit disorder*, we must ask the question “Does an appetite habit disorder meet the criteria of a disease?”

To answer the key question of whether or not alcoholism (or whatever we choose to call it, is a disease, we must look to the technical definition of “disease” and then look at the phenomena of alcoholism and see if it meets that criteria.
What is a “Disease”? 

To intelligently discuss the issue of whether or not alcoholism is a disease, we must first define the term “disease”. To do this I turned to the 24th Edition of the Stedman’s Medical Dictionary which provided the following definitions.

1. A disease is a morbus, an illness, a sickness that causes an interruption, cessation, or disorder of bodily functions, systems, or organs

2. A disease is an entity characterized by at least two of these criteria:
   (a) a recognized etiologic agent (or agents);
   (b) an identifiable group of signs and symptoms; or
   (c) consistent anatomical alterations of known body systems.

To determine if alcoholism is a disease, we must see if it meets this definition.

My position is that alcoholism is a disease. This position is shared by many prestigious organizations including the World Health Organization (WHO), the American Medical Association (AMA), and the American Psychiatric Association (APA). The Congress of the United States of America formally acknowledged that Alcoholism was a disease with the passage of the Hughes Act in 1970. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) was created to promote research on the nature of this disease. A major thrust of NIAAA has been on the biomedical aspects of this disease and much progress has been made in understanding its etiology, symptoms, and treatment.

There is a good reason for taking the position that alcoholism is a disease - alcoholism meets all of the criteria of a disease as defined by any medical dictionary or text book.

Let’s go back to the Stedman’s Medical dictionary’s definition of a disease as see if these criteria accurately describe the phenomena of alcoholism. To do this we will need to systematically answer two questions:

1. Is alcoholism “an illness or a sickness”?

   The answer to this question is yes. Alcoholism is a leading cause of death in the United States. Alcoholism is a major factor in rapidly growing healthcare care costs. Nearly 30% of all inpatient hospital days and 50% of all emergency room visits are devoted to the treatment of medical problems related to alcoholism. Anyone who has known an actively drinking alcoholic will attest to the fact that they get physically sick. This is evidence by the fact that known alcoholics have significantly higher utilization of medical treatment than non-alcoholic patients.

2. Does alcoholism causes an interruption, cessation, or disorder of bodily functions, systems, or organs?”

   3. Is alcoholism “an entity characterized by a recognized etiologic agent (or agents);”

   4. Is alcoholism “an entity characterized by an identifiable group of signs and symptoms?”

   5. Is alcoholism “an entity characterized by consistent anatomical alterations of known body systems?”

   6. Do all people who experience alcohol problems have the disease of alcoholism?”

Let’s systematically answer these six questions.

**Question #1: Is alcoholism “an illness, or “a sickness”?**

The answer to this question is yes. Alcoholism is a leading cause of death in the United States. Alcoholism is a major factor in rapidly growing healthcare care costs. Nearly 30% of all inpatient hospital days and 50% of all emergency room visits are devoted to the treatment of medical problems related to alcoholism. Anyone who has known an actively drinking alcoholic will attest to the fact that they get physically sick. This is evidence by the fact that known alcoholics have significantly higher utilization of medical treatment than non-alcoholic patients.
Even Dr. Marlatt will concede that Alcoholism is “an affliction”. There seems to be universal agreement that alcoholics become ill or sick in the medical sense of the word and seek treatment in large numbers that illness or sickness.

**Question #2: Does alcoholism cause an interruption, cessation, or disorder of bodily functions, systems, or organs?”**

Again the answer is yes. There is a definite profile of alcohol-related damage to body systems and organs that usually does not occur in people who do not have alcoholism. The major organ system that is affected is the brain. There is clear evidence from neuropsychological studies that alcoholics have cognitive impairments related to the organic damage caused by chronic alcohol poisoning to the brain. The DSM IV clearly identifies and differentiates “substance related organic mental disorders” and describes their direct correlation to alcoholism.

Many other organ systems are also affected. There is a specific profile of alcoholism related damage to other organ systems. The liver, the pancreas, the heart, the endocrine systems among others are all affected.

Alcoholism can be a fatal disease. Many alcoholics die from their alcoholism each year. Why? Because if the alcoholic continues to drink heavily and regularly the organ system problems will become fatal. The NIAAA informs us that alcoholism is the third most common cause of death next to cancer and heart disease among adult Americans.

**Questions #3: Is alcoholism “an entity characterized by an identifiable group of signs and symptoms?”**

Again, the answer is yes. But here we must be careful to make careful distinctions between alcohol use, alcohol-related problems, and alcoholism.

About 70% of all Americans use alcoholic beverages on a regular enough basis to be defined as “drinkers”. About 60% of these drinkers (40% of all Americans) consume alcohol in moderation and experience no problems. These people experience alcohol use, which definitely is not a disease. About 40% of these drinkers (30% of all Americans) consume large amounts of alcohol and experience some problems as a result of their use. These people experience alcohol-related problems which DSM-IV defines as alcohol abuse.

Since these alcohol abusers do not develop biomedical conditions related to their alcohol abuse, this group does not technically meet our definition of disease. Alcohol abusers, however, are engaging in high risk behaviors that can lead to alcoholism.

About 10% of these drinkers (7% of all Americans) develop biomedical complications as a result of their alcohol abuse. These people definitely meet the criteria of having a disease. For the moment, let’s restrict our attention to this 10% of people with alcohol-related biomedical conditions.

There are clearly described signs and symptoms that are associated with alcoholism. These signs and symptoms were originally identified at the turn of the century and have been studied and clarified since. Many researchers and leading professional organizations including the American Medical Association and the American Psychiatric Associate recognize these signs and symptoms. With that in mind let’s briefly review the history of the discovery and refinement of the signs and symptoms of alcoholism.

The IOM Report to Congress based its reasoning upon a model that describes alcoholism as existing on a continuum of alcohol-related problems. Let’s look at how we can use this model to correctly reason to the conclusion that there are a large numbers of individuals that have a profile of alcohol related problems (i.e. signs and symptoms) that meet the criteria of having a disease.
Continuum of Alcohol Problems Model

According to the Institute of Medicine Report to Congress, alcohol problems exist on a continuum of severity from mild to severe. The following is one set of criteria that can be used to place different profile of alcohol related problems on this continuum.

1. **Mild problems** create subjective distress and interpersonal conflict but do not result in social or occupational impairments.

2. **Moderate problems** create periodic or persistent social and occupational impairments and minor health problems but do not result in incapacitation.

3. **Severe problem** result in periodic or persistent incapacitation as a result of severe physical, psychological, or social problems.

**Mild Alcohol Problems:**

People with mild alcohol problems (i.e. those who have experienced only subjective distress or mild interpersonal conflicts related to alcohol or drug use) do not, at that moment, meet the criteria of having the disease of alcoholism because: there is not a full and complete profile of signs and symptoms and there is not sufficient evidence of a disorder marked by structural or functional impairment.

Some individuals who experience mild problems with alcohol or other drugs will progress to more severe problems. Others will not. In those who experience a progression from mild to severe problems, the rate of progression will vary from gradual to rapid. This variance in the rate of progression, as we will see latter, can form the basis of developing subtypes of alcoholism.

There is currently no absolutely reliable way to predict which individuals will experience progression and which will not, although risk of progression increases with evidence of genetic, prenatal, and familial risk factors, and early age onset of initial problems.

It is reasonable to assume that the mild alcohol-related problems in individuals who eventually progress to severe problems may, in fact, be the early stage symptoms of alcoholism. Since, however, reliable predictions cannot yet be made as to who will and will not experience progressive problems, definitive diagnosis based upon mild alcohol problems cannot yet be made. As a result it is best to describe such individuals as being in high risk of developing alcoholism rather than conferring the definite diagnosis of alcoholism. As can be seen, as of this presentation it is not appropriate to describe the mild alcohol-related problems as a disease.

**Severe Alcohol Problems**

People who have developed severe problems with alcohol and drugs have a consistent profile of alcohol and drug related problems that can appropriately be classified as a disease. Most individual who develop severe problems with alcohol and drugs share the following signs and symptoms: (1) Severe subjective distress; (2) severe interpersonal conflicts; (3) severe social and occupational problems; and (4) incapacitation as a result of severe physical, psychological or social problems.

The profiles of the symptoms of patients with severe alcohol problems have been well mapped and constitute the basis of many well accepted diagnostic typologies that meet the criteria of a disease. Let’s review some of the most notable.

**Moderate Alcohol Problems - The Borderline Cases**

It is clear that people with mild alcohol problems do not meet the criteria of having a disease. It is also clear that people who have severe alcohol problems do, for the most part, meet the criteria of having a disease.
Where Do We Draw The Line?

Now we must turn to a critical issue. Where do we draw the line between having the disease of alcoholism and not having it? How do we correctly classify the people with moderate alcohol problems? As of this presentation there are no definitive answers. It is important however to point out that in clinical practice these distinction are being made on a daily basis.

Some clinicians operate according to a set of decisions rules that in essence say, if in doubt, declare the client an abuser and attempt moderation training until that approach fails.

Other clinicians operate according to a set of decision rules that say: “Since no one has ever died from abstinence and many alcoholics who attempt controlled drinking and fail suffer serious problems up to and including death, if in doubt declare the person as having a disease and treat it accordingly.

Here we confront the link between diagnosis (Is it a disease or not) and treatment (Does recovery it require total abstinence or not). I will return to this issue latter. For now, let’s simply point out that we are not addressing the issue of effective treatment (i.e. abstinence vs. controlled drinking). We are addressing the issue of whether or not alcoholism or certain of its subtypes are appropriately classified as a disease.

DSM IV

Most people who have severe alcohol problems as described above meet the criteria for Substance Dependence as presented in the DSM-IV. These criteria include:

A. A Pattern of Compulsive Use marked by a loss of control over the ability to regulate use or to abstain.

B. Tolerance marked by both the need for larger amounts of alcohol to achieve the desired effect and a diminished perceived effect with the same amount.

C. Withdrawal marked by the development of a specific withdrawal syndrome upon the cessation of use or the use of the same or similar type of drug to relieve or avoid the withdrawal syndrome.

D. Substance-induced Organic Mental Disorders that result from the toxic effects of chronic alcohol and drug poisoning to the brain.

DSM IV places a heavy weighting upon the pattern of compulsive use as the primary factor distinguishing between abuse and dependence. This pattern of compulsive use is marked by the following signs and symptoms:

1. Craving: A strong desire to use the substance.
2. Loss of control over use: The tendency to use larger quantities of the substance than intended and to use the substance for longer periods of time than intended.
3. Inability to abstain: The persistent desire to cut down or control accompanied by the failure to be able to so in spite of past attempts.
4. Addiction Centered Lifestyle: The increased amount of time spent in seeking and using alcohol and other drugs resulting in the centering of major life activities around alcohol and drug use.
5. Addictive Lifestyle Losses: The tendency to give up or reduce the frequency of involvement in important life activities to accommodate the increased amount of time spent in drug seeking and using.
6. Continued Use In spite of Problems The tendency to continue to use alcohol and drugs in spite of problems.

It is appropriate to describe people with severe alcohol problems that meet the DSM IV criteria of substance dependence as having a disease. In these cases there is clear evidence of a
 syndrome (a clearly identifiable pattern of signs and symptoms) and a disorder (clear evidence that those signs and symptoms have created both functional and structural impairment.

**Question #4: Is alcoholism (defined as drinkers who develop biomedical complications from alcohol abuse) “an entity characterized by consistent anatomical alterations of known body systems?”**

The answer to this question is definitely yes. There is no doubt that alcoholism produces a syndrome marked by predictable signs and symptoms. There is also no doubt that these signs and symptoms frequently create functional and structural damage to the brain and other organ systems. These facts, however, do not address the question of why a person would voluntarily keep drinking and using drugs until brain and organ system damage developed.

This question can be answered, in part, by understanding the relationship of brain reward mechanisms and the behavior of using alcohol and drugs. This demonstrates that the tendency toward alcohol seeking behavior is strongly linked to progressive alterations in the function of the brain, and in late stages to the development of structural damage to the brain and other organ systems.

Recent NIAAA Research clearly shows that there are biomedical processes that occur within the brains of alcoholics that reinforce the regular and heavy use of alcohol. These biomedical brain reinforcement processes are different from the classic alcohol withdrawal syndrome. Let me quote the summary of this research reported in the Alcohol Alert from NIAAA for July of 1996.

1. People will tend to repeat an action that brings pleasure or reward. The pleasure or reward provided by that action is called positive reinforcement.
2. Certain behaviors, especially those associated with survival needs, are linked to biochemical processes within the brain that cause powerful biological reinforcement for these behaviors.
3. This biological reinforcement is related to the release of specific brain chemicals when the behavior is performed. These brain chemicals produce a sense of pleasure or reward.
4. Evidence suggests that Alcohol and Other Drugs of Abuse (AOD’s) produce chemicals that are surrogates of these naturally occurring brain chemicals that produce biological reinforcement.
5. As a result the use of AOD’s cause a rewarding mental state (euphoria) that functions as a positive reinforcer of the initial use of AOD’s. This rewarding mental state is defined as euphoria. (Euphoria is a state that is separate and distinct from the symptoms of intoxication).
6. As a result individuals who receive positive reinforcement for AOD use as a result of the production of these brain chemicals are more likely to engage in drug seeking behavior and to use drugs regularly and heavily.
7. The biochemical reinforcement that results from alcohol and drug use is more powerful and persistently reinforcing than the biomedical reinforcement provided by other survival related actions.
8. As a result, people who experience this are more likely to feel that the use of alcohol and drugs is more important than engaging in other vital survival linked behaviors. As a result they will tend to use AOD’s instead of actively meeting other vital needs.
9. This perception that alcohol and drug use is more important than meeting other needs results in alcohol-seeking behavior.
10. After alcohol seeking behavior has been established, the brain undergoes certain adaptive changes to continue functioning despite the presence of alcohol. This adaptation is called tolerance.
11. Once this tolerance is established, further abnormalities occur in the brain when alcohol is removed. In other words, the brain looses its capacity to function normally when alcohol is not present.
12. This low-grade abstinence-based brain dysfunction is distinct and different from the traditional acute withdrawal syndromes.

13. This low-grade abstinence-based brain dysfunction is marked by feelings of discomfort, cravings, and difficulty finding gratification from other behaviors.

14. This creates a desire to avoid the unpleasant sensations that occur in abstinence. This desire to avoid painful stimuli is called negative reinforcement.

15. People who experience biological reinforcement (both positive and negative) are more likely to use alcohol and drugs regularly and heavily.

16. People who use alcohol and drugs regularly and heavily are more likely to develop physical dependence syndromes marked by tolerance and classic withdrawal symptoms, and biomedical complications resulting from alcohol and drug use.

17. There is evidence that people who are genetically and prenatally exposed to addiction may have pathological brain reward mechanisms.

18. This pathological brain reward mechanism is marked by a below average release of packets of brain reward chemicals when not using the drug of choice. When the drug of choice is used the brain releases abnormally large amounts of brain reward chemicals. When not using, the person experiences a low grade agitated depression and a sense of anhedonia (the inability to experience pleasure or find satisfaction in any activity). This feeling creates a craving for something, anything that will relieve the feeling.

19. When the person finds the drug of choice that releases large amounts of brain reward chemicals, the person experience a powerful sense of pleasure or euphoria. The experience feels so good that the client begins seeking that experienced.

**Progressive Symptoms of Addictive Brain Reward Mechanisms**

Let's explore the progression of symptoms that may be related to this pathological brain reward mechanism.

1. *Chronic Low Grade Agitated Depression:* Due to abnormally low release of brain reward chemicals the person experience a chronic state of low grade agitated depression. This state is dysphoric and creates an urge to find something, anything that will relieve this state.

2. *Biological Reinforcement:* The person experiments with a drug of choice that activates the release of brain reward chemicals. This results in an intense feeling of euphoria and personal well being. For the first time the person’s mood normalizes and they feel good. They can experience pleasure. Whatever feelings they are experiencing prior to use becomes normalized. As a result the drug of choice can be used as a psychoactive medication.

3. *Obsession, Compulsion, and Craving:* The biological reinforcement creates a positive experience. The person trains themselves in the process of euphoric recall. they remember how good the experience was and exaggerate the memory of the good feelings. This thinking about the euphoria stimulates the limbic system to develop and emotional urge to repeat the experience. This emotional urge, as it grows strong, can activate a primitive tissue hunger for the drug.

4. *High Tolerance:* The person is able to use large amounts of the drug of choice without becoming intoxicated or impaired. As a result they can use heavily without apparent adverse consequences.

5. *Hangover Resistance:* The person experiences minimal sickness on the morning after using alcohol and drugs. This rapid recovery allows the person to resume use rapidly and to use the drug of choice frequently.

6. *Addictive Beliefs:* As a result of the experiences created by the biological reinforcement, high tolerance, and hangover resistance the person comes to believe that the drug of choice is good for them and will magically fix them or make them better. They come to view people
who support their alcohol and drug use as friends and people who fail to support it as their enemies.

7. **Addictive Lifestyle**: The person attracts and is attracted to other individuals who share strong positive attitudes toward the use of alcohol and other drugs. They become immersed in an addiction centered subculture.

8. **Addictive Lifestyle Losses**: The person distances people who support sobriety and surround themselves with people who support alcohol and drug use.

9. **A Pattern of Heavy and Regular Use**: The pattern of biological reinforcement has motivated the person to build a belief system and lifestyle that supports heavy and regular use. The person is now in a position where they will voluntarily use larger amounts with greater frequency until progressive addiction and physical, psychological and social degeneration occur.

10. **Progressive Neurological and Neuropsychological Impairments**: The progressive damage of alcohol and drugs to the brain create growing problems with judgment and impulse control. As a result behavior begins to spiral out of control. The cognitive capacities needed to think abstractly about the problem have also been impaired and the person is locked into a pattern marked by denial and circular systems of reasoning.

11. **Denial**: The client is unable to recognize the pattern of problems related to the use of alcohol and drugs. When problems are experienced and confronted

12. **Degeneration**: The person begins to experience physical, psychological and social deterioration. Unless the person develops an unexpected insight or is confronted by problems or people in their life the progressive problems are likely to continue until serious damage results.

13. **Inability to Abstain**: The person attempts to abstain but is plagued by acute withdrawal and the longer term withdrawal symptoms associated with chronic brain toxicity. In addiction the low grade agitated depression and symptoms of anhedonia return. The combination of problems impair judgment and impulse control. When coupled with the addictive belief systems and the deeply ingrained pattern of obsession, compulsion, and craving the person find themselves unable to maintain abstinence and relapses.

**Question #5: Is alcoholism “an entity characterized by a recognized etiologic agent (or agents)?”**

The answer again is yes. The etiology of alcoholism is a complex interaction between genetic and prenatal factors, impaired neurological development resulting from impoverished environment in infancy and early childhood, and psychosocial factors that support the heavy and regular use of alcohol.

**Public Health Model**: The World Health Organization Provides an excellent model for understand the role of environmental factors in the etiology of disease. According to this model etiological factors interact with environmental factors to produce disease. Distinction need to be made between three elements: 10

E. **The Susceptible Host**: Different people have different biochemical reactions to the ingestion of alcohol. Some of these reactions create resistance to alcohol related damage. Other people have biochemical reactions that make them more sensitive to damage and hence more vulnerable.

F. **The Toxic Agent**: In this case the toxic agent is alcohol. The exposure to alcohol is a necessary catalyst for the development of the disease in a susceptible host.

G. **A Permissive Environment**: The environment will increase or decrease the likelihood of exposure to the toxic agent (alcohol). The more a culture reinforces the use of alcohol as necessary or desirable the greater the likelihood that more members of the culture will be exposed to the toxic agent.
Genetic and Prenatal Predisposition

There is convincing evidence that there is a genetic and prenatal factors can create a predisposition to alcoholism. This evidence is reviewed in depth in the series of reports to congress on alcohol and health submitted by the NIAAA. The most recent reviews of the genetic research occurs in Alcohol and Health Research World, Volume 19, Number 3, 1995.

1. Impaired Neurological Development in Childhood: There is a growing body of evidence that an impoverished environment during early infancy can impair neurological development and as a result prevent for genetic and prenatal tendencies. Impoverished environments create chronic states of pathological anxiety through abuse. Impoverished environments also deprive the infant of sufficient sensory stimulation needed for adequate development of the psycho-sensory system. This psycho-sensory system is closely related to the production of reinforcing brain chemical.

Psychosocial Predisposition: There is also convincing evidence that psychological and social factors can increase the risk of future alcohol and abuse and alcoholism. There is an interaction between personality style, lifestyle, culture, and social system. When these psychosocial variables encourage the following behaviors related to alcohol and drug use the prevalence of addiction increases. The factors the increase the incidence of alcoholism appear to be psychosocial factors that:
1. Promote the use of alcohol and drugs as safe, normal, and low risk behaviors
2. Support frequent use.
3. Support heavy use.
4. Promotes intoxication as normal.
5. Views intoxication a reason to exempt individuals from personal responsibility for the consequences of behaviors while intoxicated

Question #6: Do all people who experience alcohol problems have the disease of alcoholism?"

The answer here is no. Not all people experience alcohol related problems have the disease of alcoholism. There are different subtypes of alcohol related problems. To assume that all subtypes of alcohol related problems are caused by the same etiology is a serious error. All alcohol problems cannot be accounted for by a single disorder. The issue of whether alcoholism is or is not a disease can only be intelligently discussed in relation to each of its known sub-types. 11

The judgment as to which subtypes of alcoholism are appropriately called a disease needs to be based upon the use of standard criteria which we just reviewed that allows us to distinguish a disease from a non-disease. There are specific subtypes of alcoholism that clearly and undeniable meet the criteria of a disease. There are other subtypes of alcoholism that do not meet the criteria of a disease.

All subtypes of alcoholism have known etiologies that result from a complex interaction among physical, psychological, and social predisposing factors. Not all sub-types have strong physiological predisposing factors. The etiological factors can be described in one of three broad categories:

1. Physiologically Dominant Predisposing Factors: These are factors related to genetic, prenatal and early childhood experiences that alter or predispose brain function to favor the development of an addiction to alcohol. Traditionally physiologically dominant predisposing factors lend weight to defining a disorder as a disease.

2. Psychosocially Dominant Predisposing Factors: These are factors related to psychological predisposition (as reflected in thoughts, feelings, and behavioral habits that set the stage for heavy, regular and abusive drinking) and social predisposition (as reflected in cultural practices and social systems that support the regular, heavy, and abusive use of
alcohol). Traditionally psychosocially dominate predisposing factors when presenting in isolation from physiological predisposing factors lend weight to the argument that a disorder is not a disease.

3. Mixed Etiological Features: Most subtypes of alcoholism have mixed etiological features consistently of differently balanced profiled o physiologically dominant and psychosocially dominant predisposing factors.

The New Paradigm for Alcoholism

There is clear evidence that a new diagnostic paradigm is emerging that is reframing the definition of disease from one that is physiological symptoms only to one that is biopsychosocial in nature. Therefore the clear distinction between physical and psychosocial predisposing factors may become less important in future definition of disease.

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About the Author

Terence T. Gorski is internationally recognized for his contributions to *Relapse Prevention Therapy*. The scope of his work, however, extends far beyond this. A skilled cognitive behavioral therapist with extensive training in experiential therapies, Gorski has broad-based experience and expertise in the chemical dependency, behavioral health, and criminal justice fields.

To make his ideas and methods more available, Gorski opened The CENAPS Corporation, a private training and consultation firm of founded in 1982. CENAPS is committed to providing the most advanced training and consultation in the chemical dependency and behavioral health fields.

Gorski has also developed skills training workshops and a series of low-cost book, workbooks, pamphlets, audio and videotapes. He also works with a team of trainers and consultants who can assist individuals and programs to utilize his ideas and methods. Terry Gorski is available for personal and program consultation, lecturing, and clinical skills training workshops. He also routinely schedules workshops, executive briefings, and personal growth experiences for clinicians, program managers, and policymakers.

Mr. Gorski holds a B.A. degree in psychology and sociology from Northeastern Illinois University and an M.A. degree from Webster's College in St. Louis, Missouri. He is a Senior Certified Addiction Counselor in Illinois. He is a prolific author who has published numerous books, pamphlets and articles. Mr. Gorski routinely makes himself available for interviews, public presentations, and consultant. He has presented lectures and conducted workshops in the U.S., Canada, and Europe.

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