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THE RELATIONSHIP BETWEEN PSYCHOPATHOLOGY AND THE ADDICTIONS

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INSIDE

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Editors' Note: This article is an edited transcript of the presentation by Doctor Reder at the 1988 Review Course. It was chosen for publication because of the importance of the area on which it focuses – the need for integration of the knowledge and experience of the psychiatrist with that of the addictionist – and because Doctor Reder's observations provide helpful insight into common clinical problems.

As we talk about the history of the relationship between psychiatry and the addictions—the types of relationships which can occur between variables, the specific types of psychopathology, and the principles of treatment—it's important to remember that the research and the methods are in their infancy, that chemically dependent patients and particularly patients with dual diagnoses are a very difficult population to study, and that the results of studies reported in the literature are often conflicting. For all these reasons, we need to draw conclusions rather carefully. Let me begin by reviewing some of the relationships between psychopathology and the addictions.

■ Co-existing vs. causal factors

Certain psychiatric disorders (such as antisocial personality disorder and affective disorder) occur more frequently in alcoholics than one would predict from their prevalence in the population. It may be for this reason that psychopathology has been seen as the *cause* of addiction, with the corollary assumption that if the depression (for example) were successfully treated, the alcoholism or other addiction would resolve. However, longitudinal studies show that such psychopathology is the *result* of addiction more often than its cause.

It is crucial in understanding the relationship between chemical dependency and psychiatry to make criteria-based diagnosis. So I refer you to DSM-III-R once again and urge you to ask questions when a patients says, "I'm real depressed, Doc." You've got to find out more about what that really means. It is important to define terms carefully so as not to confuse, for example, sadness or grief with major depression, and to avoid confusing transient situational dysphoria with a primary affective disorder.

Misdiagnosis is extremely common, particularly if people are psychiatrically diagnosed in the context of the drug use.

Sadness, for example, which is a normal reaction to stress, is experienced by all people, but sadness isn't necessarily the same as grief. Grief is a specific response, fairly intense, but temporary and related to loss. Both of those are different from depression which can be a life threatening illness. The word "depressed" under those circumstances doesn't necessarily translate into a need to treat.

The patients we see, particularly when we see them during withdrawal or during their early recovery phase, are dealing with significant losses. Besides having lost their jobs, their spouses, their friends, their money, and so on, they're also in the process of giving up their chemicals, their old coping mechanisms, their lifestyles. Their self esteem is often minimal. Their reality testing is being completely overhauled, and they don't know who to trust or how to trust. Thus, it is not surprising that we see people who feel hopeless, helpless, guilty, empty, and bewildered. They need to grieve, or mourn, and we need to help them. But 85-90% of the time we don't need to treat their grief, hopelessness and guilt with pharmacologic agents. We have to carefully distinguish symptoms, syndromes, or circumstances which require immediate attention and intervention from the dysphoric affects and behaviors seen during active withdrawal or early recovery, because the latter will resolve with abstinence and time.

There is no research evidence to suggest that there is an addictive personality that can be predicted in any way from underlying personality traits. I think we have learned that it is in fact the other way around: that chemical dependency causes personality distortions. Recent longitudinal prospective studies by people like Valliant show that psychopathology is more often the result of, not the cause of, chemical dependency. Furthermore, the presence of psychopathology is related to a number of factors and differs for different drugs as well as different groups. For example, studies show more preexisting psychopathology in opioid addicts than in alcoholics across the board.

■ **Predisposing factors**

Psychopathology can predispose a person to chemical dependency. The more normative the drug is in a society the less importance psychopathology will be as a risk factor. For example, Jewish alcoholics will have a much higher incidence of psychopathology associated with their addiction than will Irish alcoholics because use of alcohol is accepted in the Irish society and culture to a greater extent than it is in the Jewish society and culture. As marijuana use became more wide spread in our society, the relationship between deviance and psychopathology in the users of marijuana diminished dramatically. If you look at a bunch of heroin-using kids in the suburbs and a bunch of heroin-using kids in the inner city, the kids in the suburbs invariably have a higher incidence of psychopathology that do the kids in the urban setting. So it is important to keep those things in mind as you think about the relationship between what you're seeing as a primarily or predominantly chemical dependency issue or a primary psychopathology.

Chemical dependency causes personality distortions.

The classic example of a predisposing condition for chemical dependency that has been studied more than any other is antisocial personality disorder (ASP). This is the most prevalent psychiatric disorder associated with chemical dependency. It is most common among males. The criteria that you must use to diagnose antisocial personality disorder are very clear. Drinking behavior with a major life problem,

where the major life problem is secondary to the drinking and precedes the onset of the symptoms of antisocial personality disorder, is *not* predisposing antisocial personality disorder.

■ **Modifying the course**
Psychopathology can modify the course of an addiction, and vice versa. The course of a psychiatric illness can be changed with alcohol or other drug use, usually increasing the severity and the rapidity of the progression of the illness, with more frequent hospitalizations. Alcohol or drug use changes the symptom picture and usually worsens the prognosis.

What was originally a coping mechanism becomes a major barrier to coping.

It shouldn't be surprising to us that psychiatric disorders or states which are characterized by poor impulse control — for example, poor object relations, the ability to relate to other people, or negative mood states — would be associated with worsening of whatever other condition the patient has. That is to say, the degree of severity of the psychiatric symptoms is a more accurate prognosticator than is the specific psychiatric disorder, syndrome or symptom.

■ **Causing symptoms**
Psychiatric symptoms can develop as the result of chronic intoxication. Prolonged use of drugs of virtually any kind eventually leads to depression, increased anxiety, and increased belligerence, which are the very symptoms that many people use the drugs to treat. Those very symptoms emerge even more dramatically as a result of the drug use. That paradox is worth noting especially for anyone who thinks that addicts or alcoholics use drugs only to get high or to be euphoric. In fact that turns out not to be the case a great many times. The initial drug use may begin and establish itself because of what is perceived to be an increase in positive affect by decreasing stress; but then continued use will lead to the stress itself. What was originally a coping mechanism becomes a major barrier to coping.

■ **Psychiatric disorders**
Lastly, we have a group of psychiatric disorders which result specifically from long term chronic drug use and lifestyle changes. This is something we had completely backwards for decades. Depression, personality changes and cognitive impairment can occur as a result of the use of drugs for a long period of time.

Remember that it's up to us as clinicians to determine which of the symptoms or symptom clusters are naturally occurring concommitants of drug or alcohol dependence during active use, during acute withdrawal, as part of protracted withdrawal, or during recovery, and which constitute a specific and separate psychiatric diagnosis which meets the DSM-III-R criteria and, therefore, need to be treated separately.

■ **Dual diagnoses**
The term dual diagnosis usually refers to patients with two Axis I diagnoses from DSM-III-R; for example, alcohol dependence and affective disorder. However, the term may be used with patients who have a substance use disorder and a personality disorder, especially where the personality disorder is severe and likely to interfere with treatment. An example is cocaine dependence and borderline personality.

The term dual diagnosis is reserved for those patients whose other diagnosis is not a consequence of their substance use. For example, patients who meet the criteria for an affective disorder during withdrawal from alcohol are not considered to

Table 1: Differential Diagnosis

Condition	Age of Onset	Clear Sensorium	Temporal Relation to Drinking	Autonomic Dysfunction
Alcoholic hallucinosis	Usually > 30	Yes	During intoxication or early withdrawal	No
Schizophrenia	Usually < 20	Depends on acuity	Unrelated	No
Alcohol Withdrawal	Usually > 30	No	Post alcoholic use	Yes

have a dual diagnosis because their secondary diagnosis, the apparent affective disorder, will resolve with abstinence.

■ **Primary vs. secondary**
There are different definitions and understandings for the distinction between primary and secondary diagnosis. Primary and secondary can refer to a temporal relationship, with no cause and effect necessarily implied. Marc Schuckit defines the primary disorder as the one which occurs first in a patient's life history. For example, a patient who meets the criteria for major depression prior to the onset of significant drug use would be said to have a primary affective disorder, and the substance use disorder would be secondary. Conversely, a patient meeting criteria of depression in the midst of long term alcoholic drinking would be said to have a primary diagnosis of alcohol dependence and a secondary, temporary diagnosis of depression.

Don't just do something; stand there.

Other authors suggest that a primary diagnosis is one which exists independently from any other psychopathology. Margaret Bean-Bayog in her work on personality changes as a result of alcoholism and George Valliant in his work on depression as a result of alcoholism, both show that it is often possible to ascribe cause as well as chronology; that is, that the depression is in fact a result of the alcoholism. In other words the alcoholism causes the depression or the personality changes. I still find that most physicians and certainly the lay public do not understand this. People still talk about the fact that if you treat the depression the alcoholism could get better. That's simply incorrect; it's backwards.

In distinguishing between primary and secondary diagnosis, it is also important to establish the relationship between a particular behavior or mood state and the stage of the alcoholism or drug dependence. Is the patient, for example, suicidal only when drunk? Diagnoses made when patients are either barely sobered up or not sobered up at all can be terribly incorrect in the long run. They can lead to a whole progression of erroneous decisions.

There are many people who ask—when they have bothered to make the determination as to what is primary and what is secondary—whether to treat sequentially or concurrently. Should these chronic dual diagnosis patients be seen in chemical dependency or in mental health programs, or do we need yet again another subspecialized dual diagnosis center? I think it is very clear from what little there is in the literature and from our clinical experience that, no matter which is primary, you should treat the chemical dependence first. So whether it's primary alcoholism or primary schizophrenia, if you don't get a handle on the alcoholism you are not going to get a handle on the patient.

■ **Affective disorders**
Alcoholism occurs more often in families whose members have affective disorders than in families without affective disorders. Family studies consistently show an association of unipolar depression in alcoholism but not in bipolar illness or schizophrenia with alcoholism.

Clinical studies show rates of depression as low as 8% and as high as 70%. The reason there's so much variability in the literature about how much depression is seen is that people use very different criteria for making the diagnosis of depression.

■ **Personality disorders**
There's no evidence that there is an addictive personality which leads to or causes addiction. In fact, Margaret Bean-Bayog has shown that people develop a syndrome like post-traumatic stress disorder as a result of alcoholism. If you think about someone who has been out of control for a long period of time, who is in denial, who has lost control, whose life has included cheating, lying, stealing, dealing, hustling drugs, it shouldn't be hard to understand how the loss of social status, family, job, would lead to serious personality changes. It seems to make so much sense that one wonders why we never thought of it in that light a long time ago.

In assessing personality disorders, psychological tests, particularly the MMPI, administered while the patient is in early recovery will virtually always be abnormal. I'm not sure that any of them gives you useful information. If you study a group of subjects longitudinally over a long term and if you have an MMPI before they start using drugs, and an MMPI when they're using drugs, and an MMPI after they have stopped using drugs for a length of time, you'll find that they go from normal to abnormal to normal. When we are looking at abnormal psychological test results during drug use or in early recovery, we're not learning very much. For that reason, I have always questioned whether we should be doing psychological testing early in recovery.

■ **Organic disorders**
We're still trying to sort out the relationship between chemical dependency and organic disorders such as, for example, minimal brain damage in childhood which persists in adults as attention deficit disorder of the residual type.

We need to remain as modest as possible in this field and to proceed with caution.

There are no good prospective studies. Khantzian reported a study of a very small subset of cocaine addicts who by careful history were identified as having minimal brain damage and attention deficit disorder residual type. This group responded to very small doses of methylphenidate with dramatic decrease in craving and no escalation of the dosage. I think that's a very unusual and interesting finding; however, I caution against using methylphenidate to treat cocaine addicts because the likelihood of turning them all into methylphenidate addicts is very great. But studies like Khantzian's raise the question of whether there is, for each of the categories of drugs, a subset of patients for whom treatment may be related to some kind of deficiency syndrome. It doesn't seem unreasonable. We have endocrine gland pathologies which are characterized by diminished thyroid hormone or insulin; perhaps we will eventually find a variety of disorders which are caused by too much or too little of a certain neurotransmitter.

■ **Psychotic disorders**
The relationships between primary psychotic disorders and chemical dependency are not well worked out. We know that the use of alcohol and drugs is common with patients with schizophrenia and other psychiatric disorders, and certainly complicates their course and leads to more frequent hospitalizations. Do drugs like PCP cause permanent psychotic illness in anyone other than those genetically disposed? Probably not. At least the evidence that we have suggests not, but that's an area that has not been well worked out yet. There is some evidence to suggest that offspring of schizophrenics are at increased risk for alcoholism as well as for schizophrenia, but that again is not well worked out.

The subject often comes up about alcoholic hallucinosis and its differentiation from chronic paranoid schizophrenia. Alcoholic hallucinosis is a very different disorder. It has a sudden onset, usually in the context of alcohol withdrawal. Schizophrenia has a long prodrome and an insidious onset. The onset of hallucinosis is later in life than schizophrenia; there's usually no family history of schizophrenia; clearing usually occurs in one to two weeks. There is no formal thought disorder and there's an occasional impairment in cognition. We need to distinguish this from alcohol withdrawal delirium where there are no seizures, there's a clear sensorium and no autonomic dysfunction.

■ **Anxiety disorders**
The presence of anxiety does not necessarily diagnostic of an anxiety disorder. Anxiety is a prominent feature of affective disorders, psychotic disorders, personality disorders, and organic disorders, as well as substance dependence disorders during all phases of intoxication, withdrawal, and recovery. Anxiety, insomnia and related symptoms may last for months or even years after cessation of drug use. This is a critical time period for deciding on appropriate indications for

Table 2: The relationship between alcohol use and affective disorder

Alcohol leads to depressive symptoms in anyone.
Some kinds of serious temporary depression can follow prolonged drinking and drug use.
Drinking can escalate during primary affective episodes.
Depressive symptoms and alcohol problems occur in other psychiatric disorders. (very important)
Some small percent of the population will be unfortunate enough to have independent primary alcoholism and primary affective disorder.

prescribing anxiolytic agents. Without a criteria-based diagnostic system, it is extremely difficult to make a diagnosis of the separate psychiatric illness of anxiety disorder.

A certain number of patients treated for chemical dependence will have generalized anxiety disorder, panic disorder, social phobias or obsessive compulsive disorder, but they're rare.

I can't caution you enough about the need for a criteria-based diagnosis of panic disorder for discrete attacks occurring within a four-week period followed by a four-week period for which there is persistent fear of having another attack. At least four of these symptoms must be present during a panic attack: shortness of breath, a smothering sensation, dizziness, a sense of pending doom, loss of control, palpitations, sweating, choking, numbness, tingling. The age of onset is usually late 20's. Certainly the presence of panic disorder predisposes to the use of alcohol and anxiolitics; there's no question about that. What remains unclear is whether chemically dependent patients are more susceptible to panic attacks. There is some anecdotal evidence that withdrawal from codeine particularly and from all the opioids is associated with an increased incidence of panic attacks.

Table 3: Treatment Principles

Allow time for symptoms to respond to the chemical free state.
Allow time for observation.
Conduct trials of treatment with only one drug at a time.
Complete a full therapeutic trial.

■ **Post-traumatic stress disorder**
There is an association between this disorder and substance abuse disorders, but the literature is not yet clear about which comes first.

Time is the most important element of treatment; allow time to pass.

■ **Treatment principles**
In the next section we'll talk about some basic diagnostic and treatment principles.

We need to be absolutely clear in the differentiation between primary and secondary illnesses since the treatment response and the overall course of the illness is going to be best predicted by the primary illness. A detailed chronologic history is absolutely crucial, family history is extremely important, as implications not only for assessment and treatment but also for primary prevention possibilities. In complex patients with overlapping symptoms, the family history may in fact be helpful in pushing you in one direction or another if you understand the genetic relationships.

The age of onset of drug use is extremely important in helping you to sort out what kinds of issues you are going to have to deal with during recovery period. Persons who begin to use drugs in their early teens during a developmentally crucial period of life are going to be damaged very differently than somebody who at age 33 gets into trouble from cocaine use.

■ **Medications**
A significant number of patients have extensive psychiatric charts which are the result of failure to make a careful diagnosis of chemical dependency. They end up with a variety of diagnoses from schizoaffective disorder to borderline personality disorder to you-name-it. Patients end up on one or two or even three psychoactive medications when they should be on no psychoactive medications. Schuckit says to wait one month; if you still have symptoms, you can treat. Margaret Bean-Bayog says, "I prefer three months." You have to decide on your own, using your own experience, but there's a period of time from one to three months that you need to wait to see if the psychiatric symptoms go away. Only after that time has elapsed, and after a careful diagnosis is made, can you address the decision of whether to treat with psychoactive medications.

If you treat too soon with an antidepressant, you may be medicating a person who is going to get better in two weeks on his or her own. You will think you have done something wonderful when in fact you have not, except confused the diagnosis.

When you have made the decision to use medications, it's absolutely crucial to do two things: conduct the trials of effectiveness with one drug at a time, and make sure you use a full therapeutic trial. Over and over again I have seen patients started on more than one drug and/or not followed long enough on therapeutic doses to allow the determination of whether treatment has had any effect.

■ **Allow time to pass**
If I leave you with only one thought for the day, it is that time is the most important element of treatment. Don't just do something; stand there. I think that's extremely difficult for us; it's virtually impossible for people who are not specifically trained to sit on their hands. To learn to not do anything is the most crucial aspect of making the appropriate diagnosis and coming up with the most appropriate treatment plan. You must allow yourself time to sort out what's going on.

The 12-Step programs are no less crucial for patients with psychiatric illness than those without psychiatric illness.

Wait before starting to treat the psychiatric symptoms or what appears to be a psychiatric disorder. You have plenty of time to do that. Remember that 85% of the time the symptoms of major psychiatric syndromes will go away during the first two or three weeks of abstinence.

■ **Individual psychotherapy**
Supportive psychotherapy is probably very helpful if it is designed to enhance the early recovery process for patients who need to spend most of their time working on how to stay sober. Any kind of uncovering, analytic, psychodynamically oriented psychotherapy is contraindicated with a person who is in early recovery.

■ **Group therapy**
Group therapy is the treatment of choice for most chemically dependent patients. For those with substantiated psychiatric illness in addition to their chemical dependency, dual diagnosis groups are in fact very helpful, and more and more of them are becoming available. The 12-Step programs are no less crucial for patients with psychiatric illness than those without psychiatric illness.

■ **In closing**
I think we need to remain as modest as possible in this field and to proceed with caution. We are really in the infancy of our knowledge. My guess is that a hundred years from now people will look back at the way we dealt with psychiatric symptomatology and chemical dependence and they'll laugh graciously behind the backs of their hands the way we might do today when we talk about the way leeches were used in the last century. □

Sanford Reder is a psychiatrist in Los Angeles. He was chairman of the Department of Chemical Dependency of CIGNA Health Plans of California from 1983 to 1990.

APPLICANTS FOR MEMBERSHIP

The names of applicants are published twice and sufficient time is allowed for comments from the members before the Executive Council acts on the applications. The first time the name appears, a biographical sketch prepared from information on the application form is included. If you have comments to bring to the attention of the Executive Council, please contact P. Joseph Frawley, MD, at (805) 687-2411, or write to him in care of the California Society office.

Samuel Osamu Mayeda, MD, FACP, is currently in prviate practice of internal medicine and endocrinology. In addition he is the Medical Director of CounterPoint Center's Chemcial Dependency Unit in Santa Ana, and the Medical Director of the Diabetes Program at United Western Medical Center, also in Santa Ana. He graduated from the Medical College of Wisconsin in 1970. He has been Assistant Clinical Professor of Medicine at UC Irvine since 1984.

John G. Nork, MD, has been Medical Director of Community Health Projects in Covina since 1989. He graduated from Columbia University in 1953, and completed a three-year residency at Duke Residency in Orthopaedic Surgery. Recently he completed a fellowship in Physical Medicine and Rehabilitation at Presbyterian Medical Center in New York City.

Other applicants are:
Daniel J. Glatt, medical student, Millbrae
Said I. Jacob, MD, MPH, Covina
□

BUPRENORPHINE STUDIED FOR USE IN TREATMENT OF OPIOID DEPENDENCE

The Anti-Drug Abuse Act of 1988 authorized $10 million dollars for NIDA to establish a program that would develop medications for the treatment of chemical dependency. This year, the Senate Judiciary Committee, chaired by Joseph R. Biden, Jr., recommended a permanent medical development program with funding of $1 billion dollars over the next decade. Funding for the Medication Development Division would be a direct appropriation from Congress.

NIDA is recruiting staff for its Medication Development Division. A director, who is being recruited from the pharmaceutical industry, has not been confirmed; however, some key staff for the division are already in place. Some come from NIDA's Treatment Research Division; others have been recruited from FDA.

The industry-FDA link is vital to the success of the division because the expertise for conducting research that FDA will accept as pivotal studies for a New Drug Application (NDA) lies primarily within the pharmaceutical industry. FDA studies must be conducted within stringent guidelines which require far more procedural documentation and record keeping than most investigators keep when conducting clinical trials.

No drug to be used for treatment for chemical dependence has ever completed all the phases of FDA review and approval. For example, methadone when used for treatment of opioid dependence is still monitored by the FDA. Naltrexone, while it was approved for use on the basis of its pharmacological efficacy in blocking opioid effects, never did complete the phase which requires acceptance of clinical studies that establish effectiveness for long-term use to prevent relapse to opioid use. LAAM (L-alpha-acetylmethadol), now called levomethadyl, is still an investigational drug, after many years of research.

Buprenorphine for treatment of opioid dependency will be the bellwether for the new division. Buprenorphine, developed by Reckitt and Colemen in England, is already FDA approved in an injectable form for treatment of pain. It is distributed in the United States by Norwich Eaton Pharmaceuticals under the trade name of Buprenex®. Although buprenorphine is FDA approved for treatment of pain, and therefore available by prescription, its use in the treatment of opioid dependence still requires an Investigational New Drug exemption from FDA.

In treatment of opioid dependence, in either a maintenance or detoxification protocol, buprenorphine is generally given in much higher doses (2mg to 8mg) than for treatment of pain (.3mg to .6mg). Since it is largely destroyed when it is taken orally, it is usually given sublingually. In Europe, New Zealand, and Australia, buprenorphine is available as a sublingual tablet; however, the tablet form is not of sufficient strength to be practical in treatment of opioid dependency. Studies in the United States have used buprenorphine dissolved in a small amount of liquid which is administered sublingually.

The Los Angeles Treatment Research Unit (LA-TRU), under the direction of Walter Ling, MD, will play a major role in upcoming buprenorphine research. With consultation from NIDA's Medication Development Division staff, the Los Angeles TRU is beginning what may be the second pivotal study using buprenorphine in treatment of opioid dependence. The first was a 180-day study of buprenorphine compared to methadone in op-

ioid detoxification conducted by Edward Johnson, MD, at the Addiction Research Center in Baltimore.

At Pizarro Treatment Center near downtown Los Angeles, the LA-TRU will conduct a study of buprenorphine as a maintenance medication. Two hundred twenty-five subjects will be randomly assigned to receive either buprenorphine 8 mg, methadone 30 mg, or methadone 80 mg. Subjects will be maintained on the medication for one year.

The Medication Development Division of NIDA has in the planning stages a multi-center study of buprenorphine. The LA-TRU will be the coordinating center for a collaborative study which will include the San Francisco TRU under the direction of James Sorenson, PhD.

It is encouraging that NIDA has involved in the Medication Development Division people who were previously with FDA and that a division director from the pharmaceutical industry is being sought. Medication development is difficult work, and the nature of chemical dependence and of drug dependent patients adds on additional levels of complexity. □

–Donald R. Wesson, MD

NEWS ABOUT MEMBERS

Joel Nathan is now the Chief of the In-Patient Alcoholism Treatment Unit at the San Francisco Veterans Administration. He left his position as Medical Director of the Stanford Alcohol and Drug Treatment Center this summer.

James Orth has left the position of Medical Director of the Good Samaratan Hospital Recovery Center in San Jose. The program was called the Phoenix Recovery Center until July of 1988, then the Parkside Recovery Center until July of 1990, when administration of the program was taken over by the hospital.

H. Blair Carlson is now the Medical Director of the Division of Addiction Medicine at the Colorado Kaiser Permanente Group, in Denver.

Jess Bromley has left the position of Medical Director of the out-patient program called "Step One" at Physicians Community Hospital in San Leandro.

Richard Sandor is the Medical Director of the new Betty Ford Center Outpatient Program in Los Angeles. He continues as the Chief of Chemical Dependence Treatment at the VA in Sepulveda.

Richard Payne is the Co-Medical Director of the Chemical Dependency Unit at the CPC San Luis Rey Hospital.

Donald Wesson has left his position at the VA Medical Center in San Francisco. He is now the Associate Director of Research at the Los Angeles Treatment Research Unit. He continues with Merritt Peralta Hospital Chemical Dependence Treatment Program where he will direct a three-year study of the effectiveness of clonidine pre-treatment on naltrexone induction symptoms.

J. Thomas Ungerleider received the Association for Academic Psychiatry's 1991 Education Award for his outstanding undergraduate seminars on substance abuse at UCLA. □

California Research Advisory Panel's Annual Report Stirs a Small Storm

In mid-August the California Research Advisory Panel issued its twentieth annual report to the governor and legislature, strongly suggesting that the "war on drugs" is a major failure and that some alterations in current drug policy might be advisable. This panel's charge is to review therapeutic and drug treatment protocols related to controlled substances, and its annual reports have tended to be technical documents of interest mostly to researchers in those fields. However, this year's report has caused considerable controversy.

"Panel: Legalize drug use in state" trumpeted one major newspaper's front-page headline. Further editorials and letters argued over the merits and hazards of the "legalization" question causing at least one of the report's principal authors some chagrin.

"We never said legalize drugs," responds Frederick H. Meyers, MD, Professor of Pharmacology at the University of California, San Francisco and Vice-Chairman of the panel. "The media just reported it that way to sell papers. What we suggested is that as current policies and laws have so obviously failed to control both individual and societal damage associated with drug use, the legislature ought to move cautiously in the direction of decriminalizing some drug use and actually increasing regulation of others."

The panel's report proposes that any valid drug policy should adhere to four principles, which are usually ignored in the policy arena. Those principles are:

1. Separately consider the different drugs involved and not contend that there is one massive drug problem;

2. Remember that the word "drugs" includes alcohol and nicotine; do not think of them as separate substances just because they are legal;

3. Distinguish between the effects of the drugs themselves and the criminal activity associated with them;

4. Design any legislation so that it is subject to change with experience.

The report's three "cautious" specific recommendations for initial changes in policy are:

1. Permit the possession of syringes and needles;

2. Permit the cultivation of marijuana for personal use;

3. Forbid the sale or consumption of alcohol in state-supported institutions devoted in part or wholly to patient care or educational activity (e.g., hospitals and schools).

Meyers contends that these are relatively conservative proposals, which should be implemented as experimental policies which could be altered as evidence of their effects becomes known. He also contends that the opposition to each proposal comes primarily from people with vested interests in the status quo, such as law enforcement officials, certain drug treatment personnel, and politicians.

In fact, the report was controversial even before the media got wind of it, as it was delayed for months by dissention among the eight members of the panel. They disagreed among themselves on the issues of decriminalizing marijuana cultivation and on procedural issues.

The report then encountered opposition from the California Attorney General's office, which refused to pay for publication of the section of the report containing the policy recommendations. Meyers and other panel members began disseminating that section using their own funds, pending resolution of the procedural issues.

Donald Wesson, MD, a panel member since 1980, was among those initially opposed to making policy recommendations even where he agreed with the positions taken. "The policy issues are not data-based and are really more philosophical questions about how the world works. I

thought having them in there might damage the objective credibility of the panel. Plus, the members of the panel had as diverse views on those issues as any group of people, with each one sure that his opinion was correct."

However, even though Wesson disagreed on some substantive and procedural issues, the Attorney General's attempt to squelch the report softened his reluctance somewhat. "I felt it was totally inappropriate for the Attorney General to try to censor the report," he says. "Fred Meyers is courageous in sticking to his convictions and using his own money to distribute the document."

Meyers and Wesson both remain hopeful that the panel's report may have some impact. "People at the extremes have dominated the debate for too long," Meyers contends. "There are many shades of grey between prohibition and legalization, and somewhere in that grey area there may be some more effective policies than anything we've yet tried." Wesson agrees that "if the debate triggered by the report contributes in any small way toward the realization that current drug control policies are irrational and should be re-thought, that would be a very desirable contribution."

—Reported by Steve Heilig who is a writer who works for the San Francisco Medical Society.

CONTINUING MEDICAL EDUCATION

aaPaa's First Annual Symposium
Loews Santa Monica Beach Hotel
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Speakers include Edward Kaufman, Thomas Kosten, Sheldon Zimberg, Marc Galanter, Peter Roy-Byrne, Floyd Bloom, David Smith, George Woody, John Chappel
Sponsored by the American Academy of Psychiatrists in Alcoholism & Addictions (aaPaa)
For information contact aaPaa Central Office, P.O. Box 376, Greenbelt, MD 20768; (301) 220-0951.

11th Annual Betty Ford Center Conference
Annenberg Center, Rancho Mirage
February 18-20, 1991
For information, call (800) 621-7322 from California; (800) 321-3690 from outside California.

ASAM's 5th National Forum on AIDS and Chemical Dependency
Stanford Court Hotel, San Francisco
February 21-23, 1991
For information, contact ASAM's conference coordinator at (404) 458-3382.

ASAM's 22nd Annual Medical-Scientific Conference
Marriott Copley Place, Boston
April 18 - 22, 1991
For information, contact ASAM's office, 5225 Wisconsin Avenue, NW, Washington, DC 20015. (202) 244-8948.