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INSIDE

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REFLECTIONS ON ADDICTION MEDICINE AND ADDICTION PSYCHIATRY

Timmen L. Cermak, MD

Editors' Note: This article is Doctor Cermak's own response to the request for comments which appears on page 6 in the "Open Letter to CSAM Members from the Scope Committee" which he chairs. Doctor Cermak said, "It is intended to serve as a springboard for the committee's work and will in no way be considered a constraint on issues or positions the committee will pursue."

Proceedings from the November 1989 "State of the Art of Addiction Medicine" published in our newsletter (Vol 16, No 2 & 3, Winter 1989) advanced some important ideas regarding the scope of addiction medicine. I am writing this article to continue our focus on the question of what lies within the legitimate purview of physicians practicing addiction medicine. In other words, what is the scope of our expertise and what are the parameters of our authority? David Smith, MD, nicely delineated these two when he said, "Because we say our field needs to become more knowledgeable about [many] areas, that does not mean that we should try to control them . . . ."

It appears to me that the task of defining the scope of addiction medicine is complicated by at least three major factors: (1) The definition of addiction itself remains unclear, except insofar as it directly relates to the phenomenon of chemical dependence. (2) There is often confusion between effective treatment of a disease and the etiology of the disease. (3) The uneasy truce that exists between psychiatry and the rest of medicine—more precisely, the tension between psychotherapy and medicine bedevils the addiction field as well, with psychiatrists occupying positions at both ends of the spectrum.

The Definition of Addiction is Unclear

The only concrete definitions of addiction remain those which directly refer to chemical dependence. As soon as we expand the meaning of the word "addiction," several things begin to happen. First, we leave science and become metaphoric. When we use the disease of chemical dependence as a metaphor, we are making comparisons between things which may not be alike in some basic

ways, but which do have some striking similarities. There are important similarities between chemical dependence and compulsive behaviors, primarily in the experience of each and the value of recovery oriented treatment approaches as opposed to insight oriented approaches. But, as the next section will explore, this does not necessarily mean that their etiologies are equally similar.

Moreover, once we broaden the meaning of addiction to include purely emotional and behavioral phenomena (i.e., not involving exogenous pharmacological factors), we complicate our understanding of chemical dependence itself. We begin undermining the hard-won acceptance of chemical dependence as a primary disease, which remains a more sophisticated concept than those of us in the field generally realize. As soon as sexual compulsions, for example, are labeled addictions, we must explain how alcohol addiction differs from other, purely behavioral phenomena. Since alcoholism does have a behavioral component, broader uses of the word "addiction" initially seem to be useful. But, broader uses become problematic by greatly complicating our perspective on those aspects of chemical dependence that are primarily pharmacological.

Addiction medicine is currently building a bigger and bigger edifice without taking care to assure that the foundation is sound. The word "addiction" occurs nowhere in our formal diagnostic categories. Do we have a coherent proposal for how the word should be used, except as it refers to chemical dependence? I suspect the answer is "No." Until we settle on a comprehensive definition of addiction, I suggest we remain focused primarily on our systemic understanding of chemical dependence and try not to exercise political power in broader areas.

Etiology is Not Determined by Treatment

Humans do not use logic very logically; as a result, physicians continually make errors about cause and effect. For example, if I give penicillin to a patient with a self-limited viral URI, we can both make the mistake of concluding that the penicillin "cured" the cold (since we both have an investment in viewing events this way). We could further compound our error by concluding that a lack of penicillin "caused" the cold. Rigorous scientific techniques (such as double blind, reproducible research protocols and Koch's postulates) are cumbersome and time consuming, but they provide the best assurance against the faulty presumptions we all make.

The effective application of Twelve-Step-oriented treatment programs and the concept of recovery, both stemming from the chemical dependence arena, to an increasingly wide range of psychological problems (for example, eating disorders and sexual impulsivity) is not proof that the causes of such problems are the same as the etiology of chemical dependence. Just as physical exercise is a valuable adjunctive treatment for a wide range of physical ailments, as well as a quality of life enhancer for people without any disease, the framework of Twelve-Step recovery is valuable for a huge portion of the population. We should not conclude that a huge portion of the population is ill.

Unfortunately, the increasing turf battles being conducted around "process addictions" (i.e., compulsive behaviors that closely resemble those seen in chemical dependents, are experienced in ways that closely resemble the experience of chemical dependence, and are often ameliorated by Twelve-Step programs, e.g., food, gambling and sexual disorders) are often being waged on the basis of faulty logic. The fact that a Twelve-Step recovery model is useful for people suffering from eating disorders or sexual impulsivity does not prove that these ailments are addictions in the same sense that chemical dependence is an addiction. Here we must make two distinctions.

Just as physical exercise is a valuable adjunctive treatment for a wide range of physical ailments as well as a quality of life enhancer for people without any disease, the framework of Twelve-Step recovery is valuable for a huge portion of the population. We should not conclude that a huge portion of the population is ill.

The "experience" of addiction is not the same as addiction itself. People who are physically addicted to alcohol often develop a pattern of minimization, rationalization, denial, shameful-

ness and projecting of blame, all of which pervasively mold experience of themselves and their world. But, people can employ these same defenses for reasons other then chemical dependence. For example, eating disorders are often accompanied by the same psychological reactions found in chemical dependence, and thus the experience of each has a great deal in common. This does not mean that the etiologies are the same.

People can be physically and/or psychologically addicted to psychoactive chemicals. It is clearly the latter facet of addiction that provides most of the commonalty of experience among all the addictions. We still know precious little about psychological addiction. From the standpoint of etiology, we have not yet adequately clarified the difference between "psychological addiction" and "obsession," nor the difference between "craving" and "compulsion." The addictions field has demonstrated that, from the standpoint of treatment and recovery, concepts such as addiction and craving communicate more effectively with clients than phrases such as obsession and compulsion. However, this fact does not throw any light on the etiology of these phenomena.

Lest readers believe that I fault the chemical dependence field more than other fields, let me describe an error of logic to which many in psychiatry fall prey with embarrassing regularity. The brain is the substrate of the mind. No mental activity occurs without concomitant physical events. Unfortunately, confusion regarding cause and effect abound in this area. Once researchers find increased blood flow when a defined mental activity takes place, or once they find changes in neurotransmitter activity in people who share a diagnosis, the physical realm is automatically declared the "cause" of the mental realm. This is undoubtedly true in many cases, but is quite false in others. For example, when I feel anxious, measurable amounts of a fluid (perspiration) pass from one body compartment (sweat glands) to another (armpit). Does the perspiration "cause" the anxiety, beyond the fact that my anxiety does heighten if my shirt gets visibly soaked? By analogy, the fact that levels of adrenaline rise during panic attacks does not mean that they "cause" the attacks? It certainly does not prove that people have become "addicted" to endogenous substances.

I suspect that we in the addictions field have learned a great deal about how to approach people whose lives are out of control. On the other hand, we may not know as much as we think about the multitude of reasons people's lives get out of control. Our specialty lies in understanding how people's use of will power to regain control of their lives can be ineffective and can paradoxically become the problem. Our training gives us a framework to understand these dynamics and also a helpful language for discussing them.

The skills possessed by addiction specialists should be seen as a useful adjunct in the treatment of many illnesses. I emphasize the word "adjunct." We have much to offer to the treatment not only of eating disorders and sexual impulsivity, but also to the treatment of many other psychological problems, as well as to improving treatment compliance for chronic diseases such as hypertension and diabetes, to name but a few. However, in order to contribute to the treatment team for these disorders, we must stop trying to redefine them to fit entirely within the addictions model of etiology. We must learn to take our place alongside other specialists. If they are not yet ready to take their position alongside us, there is little we can do to force a change. With time, the truth will become apparent. In the meantime, we only slow the process of cooperation with colleagues when we attempt to push others out of clinical areas where they have established clinical and scientific expertise.

The Tension Between Medicine and Psychiatry

We are witnessing an intellectual, clinical and economic tug-of-war between addiction specialists who have psychiatric training and those who do not. This tension will color any definition of the scope of addiction medicine and make it more difficult to reach agreement. I do not have a formula for how psychiatry and the rest of medicine can learn to respect each other's expertise; nor do I have a simple prescription for how chemical dependence physicians can relate better to the rest of medicine. Nothing can be that simple. I am even willing to accept that a certain dynamic tension is both unavoidable and valuable. In this arena, I am primarily interested in pressing the case for what psychiatry teaches us until it is taken more seriously by other members of medicine who share in the treatment of our patients—not because of what we psychiatrists know, but because of our experience with what we do not know.

Reflections *(continued)*

The novel/movie, *The Prince of Tides*, will illustrate my point. In this story, Pat Conroy powerfully depicts traumatic experiences the protagonist, Tom Wingo, had with an alcoholic father and a narcissistic mother. As an adult, Tom is a tortured man, running from his memories, running from others, and running from himself. He is brought back to health by an understanding and loving psychiatrist.

The problem is that the therapist is too loving. In fact, the therapist is entirely unethical, behaves illegally, and loses all boundaries between her own tortured life and Tom's. Although the story nobilizes her work and her humanity, I found myself cringing on behalf of my profession. There are restrictions and taboos governing psychotherapists, and these restrictions exist for good reasons.

In the case of Tom Wingo, his therapist's behavior apparently did no harm. This was despite the fact that the following occurred: Tom began seeing the therapist as an adjunctive family member, helping the therapist piece together the causes of his sister's suicide attempts. Gradually, the relationship took on more and more elements of therapy itself. Then Tom was hired to teach football to the therapist's son. They began to eat meals together routinely. He was invited to dinner at her house, and they eventually fell in love and became sexual. This was all despite the fact that the therapist knew that Tom Wingo had suffered sexual trauma and emotional incest with his mother. In the real world of psychiatry, therapeutic misadventures such as he experienced would only serve to compound and deepen trauma. In addition, his psychiatrist would be expelled from the APA, lose a malpractice case if sued, and could be convicted of a felony in California.

In the end, what lies within the legitimate purview for addiction specialists will be determined by how they prepare themselves.

What does this review of *The Prince of Tides* show us about the scope of addiction medicine? I believe that the therapist depicted in this story made an obvious countertransference mistake which I think is made all too frequently by those who treat addiction without having adequate training in psychiatry. She saw Tom Wingo through her own eyes, and in light of her own needs, rather than in terms of his perspective. In most cases, the complex manifestations of countertransference are far more subtle, and that makes its detection far more difficult. I may be a bit slow, but it has taken me years to become aware with some consistency of the largely unconscious forces that are ultimately responsible for what happens in most relationships. The experience of learning and practicing psychiatry has slowly taught me something that I could never learn with my reason alone: The meaning for my patients of what happens between us stems primarily from their unconscious, not from any framework I bring into the relationship. And, the more traumatized a person was as a child, the more I must interpret their words and actions within the context of their unfinished developmental issues, while being aware that they will be interpreting my words and actions through the same filters.

Interviews with Pat Conroy, author of *The Prince of Tides*, confirm that he used his current wife as a model for the psychiatrist. This is a clear example of how patients seek in their therapists ideal figures who will fulfill their wishes. We call this transference, and it is the greatest invitation to abandon our professional duties in order to meet the patient's image of a hero. Or, in the case of so many ACAs, we are invited to "love them back to health" as though we are the perfect parent they never had. How can I explain that this expectation is both right and wrong? It is symbolically right, but rarely does a patient have an accurate image of the kind of "parent" they most need.

The ocean of ignorance and ambiguity which psychotherapists must navigate is immense. It takes most of us years to comprehend the immensity of the unknown we face, and more years to reach some idea of how to respond usefully to patients while floating about in the unknowns. Our medical training tells us, "First do no harm." Some psychiatrists become handcuffed by this dictum to the extent that they do very little, creating strained relationships in which patients feel excessively watched and scrutinized. However, if more physicians understood the power of unconscious forces controlling them and their patients, they would find themselves equally constrained.

Working in the addiction field does not give people license to ignore the psychiatric realities affecting them and their patients. We must strive to help non-psychiatric addiction specialists understand that the forces with which they are interacting cannot all be accounted for and understood by the dynamics of addiction. A Twelve-Step recovery model is useful as an adjunct when dealing with survivors of childhood trauma, but it does not adequately explain the unconscious forces that prevent many people from achieving recovery.

Until addiction specialists begin to develop better understanding of the unconscious, and how the cunning, baffling and powerful forces of transference and countertransference determine much of what happens in treatment, they will continue to look like bulls in china shops when they step beyond the narrow field of chemical dependence. The primary source of such training is years of intensive supervision. In the end, what lies within the legitimate purview for addiction specialists will be determined by how they prepare themselves. We do not currently require much psychiatric training for a physician to claim a specialty in addiction. As long as this is the case, we will find the path to treating addictive behaviors (i.e., the "process addictions") obstructed. There are legitimate reasons for this obstruction. As long as the addiction field does not see and appreciate these reasons, the need for obstruction will remain. It is in our interests to see that this is not simply a turf battle, but a striving for knowledge, understanding and efficacy which can be undertaken mutually.

I have advanced these points of view not to attack the addictions field, but rather to save it—from itself and its opponents. I am proud to identify myself with the chemical dependence field. Its multidisciplinary nature and the openness of addiction specialists to Twelve-Step influences have not only produced great creativity in the treatment of chemical dependence, but also have significant contributions to offer psychiatry in general. My experience in addiction medicine has profoundly impacted my practice of psychiatry, even with patients who have no history of addiction. For example, I now see denial as both a symptom and a defense. The use of self disclosure in chemical dependence treatment has helped me become a more interactive therapist. I have greater comfort discussing spiritual and existential issues. I no longer automatically value insight over action. I think more in terms of family systems. I understand how treatment exists along a continuum, from concrete behavioral approaches to more traditional psychotherapy. And I have a framework for understanding will power and "hitting bottom" that has no direct parallel in psychiatric training.

My experience in addiction medicine has profoundly impacted my practice of psychiatry, even with patients who have no history of addiction.

Addiction medicine is the not only source of experiences which would have impacted my practice of psychiatry as I outlined above. But it is the field in which I matured professionally, and I owe it a great deal. Above all, I feel a responsibility to the patients who have taught me so much to keep addiction medicine as effective, and chemical dependence treatment as available, as possible. They deserve my loyalty.

Summary

I suggest we will be better able to answer the question of what lies within the scope of addiction medicine if we maintain awareness of the following:

What addiction specialists need to know and what they should have authority over are separate questions.

The scope of addiction medicine is impossible to determine until addiction itself is better defined.

Effective treatments do not provide reliable, post hoc reasoning regarding etiology.

Just as psychiatrists require training in the basics of chemical dependence, addiction specialists require training in the basics of psychiatry.

The manner in which we conduct our debate about the scope of addiction medicine is as important as the conclusions we draw. A collaborative spirit will be promoted by remembering that humility is the foundation of integrity, both personally and professionally, individually and collectively. □

Open Letter to CSAM Members from the Committee on the Scope of the Field of Addiction Medicine ("The Scope Committee")

Timmen L. Cermak, MD, Chair

Decisions affecting our professional identity and economic future are being made. The consequences will be pervasive and profound. They have the potential to alter our field permanently, for better or worse. In order to arrive at good decisions, we must find a process that is fair, open, and thoughtful. We must also be willing to place principles above personalities.

When CSAM began the current certification process, in 1983, we called attention to an important question – what body of knowledge defines specialists in the treatment of chemical dependence? That question is being addressed now on a new level as ASAM explores the potential for specialty status via CAQs, a Conjoint Board, etc. At the same time, the establishment of a CAQ in addiction psychiatry by the American Board of Psychiatry and Neurology means that the decisions affecting us are being made from an increasing number of directions.

In October, ASAM established a committee to prepare a report on the content of addiction medicine.

At its October board meeting, ASAM established a committee to prepare a report on the content of addiction medicine, co-chaired by current president Anthony Radcliffe and president-elect Anne Geller. At its January Executive Council meeting, CSAM recognized the significance this ASAM report could have, and chose to explore how our state chapter understands the same question. Therefore, CSAM established its own "Scope Committee" (Committee on the Scope of the Field of Addiction Medicine). The work of this committee will provide CSAM and the CSAM Executive Council a solid foundation and clear direction for interacting with ASAM's report.

The Scope Committee's mission is to identify issues related to the boundaries of the practice of addiction medicine, and to develop a paper which examines them from several different viewpoints. One objective is to elicit, clarify and distill the opinions of CSAM members in order to render a majority opinion, with a complete representation of dissenting viewpoints. The purpose of this process is to subject our opinions to open (free) debate. A consensus reached after we have worked together to identify and analyze the foundations of our opinions will serve us well in the long run. Reaching a well-grounded opinion on the parameters and content of the field of addiction medicine will strengthen the field. Because "good fences make good neighbors," and clear boundaries are necessary for functional relationships, our efforts will enhance the acceptance of addiction medicine by the medical profession as a whole. If we achieve this goal, we will increase the integrity, legitimacy and security of our field. At the same time, consensus about what lies within and what lies outside addiction medicine will increase the overall quality of treatment provided to our patients.

The first step in searching for complex answers is often to explore the question we are asking. Does the question already create a framework that both guides and, perhaps too rigidly, controls our thinking? It occurs to me that there are at least four important words in the name of this new committee that create such a framework. I will take each one in order and outline some of the considerations which they introduce.

Scope

We can interpret the word "scope" in at least three ways related to professional standards and privileges:

- What ought to be known and what skills possessed by physicians working in the field of addiction?
- Regarding professional privileges, what lies within the legitimate right of addiction specialists to treat?
- What lies within the *exclusive* right of addiction specialists to treat?

Field

It is important to distinguish the field from the players upon that field. ASAM and CSAM are societies of some of the players (i.e., physicians) on the field of addiction. Should the Scope Committee restrict itself to opinions about the role and functions of the physicians

Consensus about what lies within and what lies outside addiction medicine will increase the overall quality of treatment provided to our patients.

in the field? Or should we be concerned with defining the broader "field" upon which all addiction specialists play? If we choose this latter course, then we must also be willing to define parameters for the medical portion of the addiction field, as well as its relationship to the non-medical portions of this field (see the section on "Medicine" below).

A corollary of the above questions involves the very raison d'etre for our Society: Have we come together primarily to promote the interests of chemically dependent patients, or the interests of those who treat chemical dependence? While these are not necessarily mutually exclusive purposes, there are times when one will take precedence over the other. At those times, which purpose does our Society wish to serve with the greater vigor?

Addiction

At the core of the challenge facing us in determining the scope of the field of addiction medicine lie ambiguities which have arisen around the word "addiction." Established medical nomenclatures (such as DSM-III-R) do not use this word, while most existing definitions simply rework accepted definitions of chemical dependence. The central question here involves which of the following concepts CSAM members want the term "addiction" to refer to:

- chemical dependence only
- the "process" addictions (compulsive behaviors that closely resemble those seen in chemical dependents, are experienced in ways that closely resemble the experience of chemical dependence, and are often ameliorated by Twelve-Step programs; e.g., food, gambling and sexual disorders)
- both

Even if our Society's position is to limit the term addiction to chemical dependence, we must decide what our systemic approach to addiction should include. Should specialists in addiction medicine also have competence in family therapy, treating young children of substance abusers, adult children of substance abusers, co-dependence . . . ? What role should addiction specialists take in treating the very common food, gambling, sexual, etc., disorders found in chemical dependents and members of their families?

Finally, it would be helpful to our purpose to explore the very origins of the word "addiction." Is it possible that the innocent change of name from AMSA (American Medical Society on Alcoholism) to ASAM (American Society of Addiction Medicine) introduced or adopted the term "addiction" before all the implications were fully understood? On the other hand, was this change a masterful stroke that opened our doors to a more creative understanding of the field?

I am publishing this open letter with a request for written responses from all readers.

Medicine

A long list of difficult questions are raised by the relationship of medicine to chemical dependence:

- What is the role of medicine in treating addictions?
- What can physicians do for addicted patients that non-physicians cannot do?
- What can physician addiction specialists do for the rest of medicine, in terms of education about chemical dependence, that could not be done by non-physicians?
- What are the advantages and disadvantages of restricting membership in our society to physicians?

In taking on responsibility for shepherding CSAM's Scope Committee through its important work, I have no interest in fomenting more turmoil than necessary. I have no interest in opening questions that have already been answered to our satisfaction after difficult and earnest debate. On the other hand, I do not shy away from a candid debate, nor do I want to look naive by pretending that the questions facing us are not fundamental to our Society's mission.

In consultation with the Executive Council of CSAM, I am publishing this open letter with a request for written responses from all readers.

If you are interested in becoming a member of the Scope Committee, it is especially important for you to submit your views in writing, as I will be nominating members for the committee based in part on the responses we receive. I will use the comments you submit to identify different points of view. I want to insure that the committee will have a balance of viewpoints.

The committee will be served better by people with openness to a range of issues, incisive analytic skills and the ability to articulate the issues and the different points of view than by people wishing to promote their special interests.

If the committee performs its work with integrity, our report should be of value to the membership as a whole. In order to maintain such integrity, we will need both the honesty, and the support, of the membership as a whole. □

Consensus Grows on Needle Exchange as HIV Prevention

Steve Heilig, MPH

Two bills to permit needle exchange are moving through the California legislature. AB2525 and SB1418, identical bills, were introduced in both the Assembly and Senate in February, co-authored by Senator Diane Watson and Willie Brown, Jr., Speaker of the Assembly, and a growing list of other representatives including John Vasconcellos, John Burton, Jackie Speier, and Milton Marks. In contrast with 1989, when nobody would even talk about needles in the halls of Sacramento, a bandwagon appears to be rolling this time around, and AB2525 received unanimous approval from the Assembly's Health Committee in March.

AB2525 and SB1418 are gaining wide support.

The bills would amend the Business and Professions Code to allow possession of hypodermic needles and syringes without a prescription. They also specify that any needle exchange must be a part of a comprehensive public health program, and require broad official and public participation in developing the program and evaluation of the program reported back to the state legislature and Department of Health Services. The bill does not require any county to institute a needle exchange, but allows a local health officer to initiate a proposal to local elected officials, who must then request authorization from the state.

San Francisco is already poised to act, in the hope that the bills will pass and state law will be loosened. The San Francisco Department of Public Health has developed an extensive and comprehensive overall plan to fight human immunosuppressant virus among injection drug users, including using needle exchange. The plan focuses on the need for drug treatment on demand as a crucial component, and, because drug treatment resources are in short supply in San Francisco as elsewhere, the plan proposes to offer priority access to treatment for those who approach treatment via the needle exchange program. The exchange program itself would be a decentralized community-based effort utilizing mobile street outreach with close links to treatment resources.

In Marin County, which has a relatively small number of AIDS cases but the second highest per capita rate of infection for California counties, the Board of Supervisors in March approved a needle exchange plan similar to San Francisco.

The California Conference of Local Health Officers has recently endorsed needle exchange, with the now-standard conditions that any such program be linked to priority access to treatment, outreach education on safe injection and safe sex, HIV testing availability, access to counseling, evaluation of the program, and community input.

Both the new Brown/Watson bills and San Francisco's proposed plan were developed in close collaboration with informed experts in AIDS and addiction medicine and are garnering support from those arenas, as well as from leaders in the African-American community who previously opposed needle exchange.

The last year or so has seen a marked increase in support for needle exchange not only as an HIV prevention measure but as a means of fighting drug use as well. In America as a whole and in California in particular, 1992 may prove to be the year in which needle exchange finally comes of age as a public health measure.

Background: AIDS and Needles

The sharing of needles and syringes was one of the first identified routes of transmission of HIV, and injection drug users are a large and growing AIDS risk group. In fact, they are the second largest HIV risk group nationally and are the primary source of heterosexual transmission to women and children. There is wide variation in the prevalence of HIV among injection drug users depending on the region, with the highest estimates coming from Eastern urban centers such as New York City. There, up to half of the 200,000 users may already be infected. In major west coast cities, estimates are 5-15% of injection drug users.

At the beginning of this year, one third of the reported cases of AIDS in the United States was associated with injection drug use. Over half of the cases of heterosexually transmitted AIDS and over two thirds of pediatric cases were linked with injection drug use in some way. These proportions have grown steadily since the beginning of the AIDS epidemic.

Needle exchange programs should be linked to priority access to treatment slots.

Attempts to arrest the spread of HIV among injection drug users and their sexual contacts and offspring have included programs to distribute bleach and show people how to use it to sterilize injection drug equipment, and – in half a dozen American cities, sometimes in defiance of state laws – needle ex-

change (which might more accurately be termed needle-and- syringe exchange, since the entire injection apparatus is provided). Offering treatment for the primary drug addiction has been an important adjunct in some efforts but is hampered by a shortage of treatment resources.

Needle Exchange in California: Illegal but Essential?

California is one of 11 American states where the possession of drug injection equipment without a prescription is prohibited by law. These "anti-paraphernalia" laws are enforced erratically from place to place; the possession of an uncontaminated rig can land the holder in jail if police personnel are vigorous in following the letter of the law.

In California, even though there is no legal needle exchange program, the spread of HIV among injection drug users has been slower than in some of the "worst case" urban centers elsewhere. This situation has led some AIDS researchers and activists to feel that if action could be taken California might avoid the wildfire spread among injection drug users seen in other parts of the world.

Prevention Point

Some of those activists took the situation into their own hands. The nation's first illegal needle exchange was begun in 1988 in San Francisco by a volunteer activist group calling itself Prevention Point. Close communication with the Mayor, health officials, and the Chief of Police quickly cleared the way for this exchange program to operate on specific nights of the week in different locations where injection drug users congregate, with an unofficial "hands-off" policy. In Los Angeles and San Diego, there is a less tolerant environment and the smaller, unofficial exchanges are more "underground" and operate in fear of police persecution. Where activists have actually been arrested and gone to trial, as in Redwood City and Oakland, none has been found guilty even though the laws had clearly been violated. In fact, jurors have even volunteered to assist in the exchanges when the trials were over.

Public and professional support for needle exchange in California is strong and growing. Among AIDS experts, the concept has been supported for years as an emergency measure to be taken even before supporting evidence was available. "We're now in a state of war against AIDS, and in wartime we sometimes must do things a little differently than in times of peace," notes Mervyn Silverman, MD, MPH, President of the American Foundation for AIDS Research and former director of health in San Francisco. The San Francisco Medical Society issued organized medicine's first pro-needle exchange policy in early 1989, soon followed by the California Medical Association. Other supporting statements came from the World Health Organization, National Academy of Sciences, former Surgeon General C. Everett Koop, the National Commission on AIDS, and numerous other public health and governmental organizations.

The illegal needle exchange programs continue, hampered by chronic shortages of resources – all of which are donated and volunteered – and an inability to apply for funding due to their legal status. In San Francisco, Prevention Point, the largest needle exchange in the country, exchanges over 9,000 clean syringes per week but reaches less than 1,000 of the injection drug use population there. Volunteers with these efforts continually express the frustration of being "used" to provide what they see as an essential public health service, but not being supported in any way other than verbally by the official public health system.

In 1989, California State Senator Diane Watson (D-Los Angeles) introduced a bill which would have allowed exceptions from state law for the purpose of local needle exchanges. Despite advocacy by many public health interests, the bill failed to gain enough support. Following that, a number of public health experts and activists began recommending that local county health directors use their powers to declare a state of public health emergency in order to override the prohibitive state laws, but no such radical action occurred.

One who urged this approach was David Smith, MD, founder and medical director of the Haight

Studies show no increase in drug use and an apparent decrease in new HIV infections.

Ashbury Free Medical Clinics. In September 1990, Smith co-signed an "open letter" detailing the need for positive action on needle exchange. Among other co-signers were Doctor Silverman, UCSF Professor of Pharmacology Frederick Meyers, MD, and UCSF Professor of Dermatology and pioneering AIDS researcher, Marcus Conant, MD.

Smith's appearance was especially noteworthy, as he had initially been an opponent of needle exchange. He had spoken against it when the concept was first floated in San Francisco in 1986 and shot down by then-Mayor Diane Feinstein. Smith's original opposition was based upon the concern that has stymied official sanction of needle exchange since the beginning: That such programs may appear to sanction and enable drug use.

"My concern was from the perspective of addiction medicine more than AIDS, and it seemed to me that addiction medicine expertise was initially being ignored in discussion of this issue," recalls Smith.

"But two of my colleagues, John Watters and John Newmeyer, pointed out that this was not only an anti-AIDS measure but a low-threshold treatment for the out-of-treatment population. And now it has been shown that if education and engagement of this population is stressed, it can be really effective as a bridge to treatment of the underlying chemical dependency." Although Smith came to his supporting position prior to any real tangible evidence that this bridge was effective, he now reports that, "We have in fact had drug users coming into the clinic to seek treatment after initial contact with the needle exchange program." Confirming experience is being reported from cities around the world, and the underlying concern about inadvertent encouragement of drug use is proving to be unfounded. Studies from Europe, the United States, and elsewhere – including analysis of the illegal programs – show no increase in drug use, a decline in HIV-risk-producing behaviors, and apparent decrease in new HIV infections. Given the youth of most programs, it is still to early to assess the real impact on HIV transmission, or the long-term effect on drug treatment enrollment and follow-through. But the crucial point at this time is that the fears of the skeptics have not been confirmed, and their theories have actually been disproved in some cases. As Smith and the other experts concluded in their 1990 open letter, needle exchange can be a tool "to prevent some of the devastation of the twin epidemics of AIDS and intravenous drug use."

Needle exchange is actually an innovative way of fostering treatment and education.

An Idea Whose Time Has Come?

This growing consensus has already been reflected in the California political arena. Doctor Smith notes, however, that some skepticism remains among his colleagues in addiction medicine. "I still encounter physicians who express concerns about enabling addiction by giving the wrong message along with the needles themselves. But the counter-argument is that needle exchange is actually an innovative way of fostering treatment and education. If it occurs as a part of a community health model, linked to outreach and treatment for the population with the greatest needs, it has already been shown to work." Smith feels that needle exchange will continue to gather support as the evidence comes in. "Everybody has certain views on this subject and certain areas of resistance," he concludes. "But if conceptualized and implemented properly, needle exchange programs can reduce those concerns by demonstrating that it does, in fact, work." □

Steve Heilig is Director of Public Health and Education for the San Francisco Medical Society, and Co-Editor of the Cambridge Quarterly of Healthcare Ethics.

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1992 Review Course and Annual Meeting
November 5-7
Ramada Renaissance Hotel, Long Beach

How to Succeed with the Media

Donald M. Gragg, MD

To provide addiction medicine professionals with skills for communicating with the media and to motivate them to pursue media and other public appearances in order to get the word out faster and better—this was the purpose of the CSAM Leadership Conference, "How to Succeed with the Media," presented by John T. O'Neill, LCDC, on February 29, 1992, at the San Francisco Airport Clarion Hotel.

O'Neill is a media maven; he has the gift of gab and a natural talent for effective communication which he maximizes with specialized knowledge of media techniques. He says the key to success is to know what point you want to make and to keep the focus of the interview on that point. "Remember that your agenda is probably not the same as the interviewer's, so you have to exercise some control over how and where the interview goes."

- Develop a CORE MESSAGE, a statement of your major point that is simple, graphic and appealing.
- Learn how to BRIDGE to your core message. When being interviewed, respond to the questions in a way that returns you to your core message. For example, "And what seems even more important is...."

We learned that 55% of communications is body language, 38% is voice, and 7% is content. O'Neill recommends practicing to keep your voice in the lower registers ("the voice of authority is a low, deep voice"). He suggests that for video appearances you ask for make up. Other points:

- Avoid arguing with the interviewer or other "win-loss" dynamics. Convert differences about which you might argue into questions or issues that can be discussed. "It looks like the real issue here is...."
- In televised interviews, look at the interviewer, not the camera or the monitor. Don't shift your gaze from one to the other; viewers would see (and think) "shifty eyes."
- Don't say, "No comment." Say, "I don't have that information but I will refer you to someone who can answer your question."
- In response to hard questions, acknowledge the difficulty or complexity of the question; then answer.
- In response to hostile questions, rephrase the question, then answer. Or ask the interviewer's opinion on the subject, then discuss.

O'Neill also recommends preparation and practice. Find many ways to re-phrase your core message. Prepare "sparklers"—catchy phrases that relay your core message, such as, "Addictions are contagious; you get them from your parents and give them to your children."

Develop a "Mother Theresa" statement—a short message that is basic and not arguable, which you can always use if you get a seemingly impossible question or one for which the only appropriate answer would require far more time than you have.

Respond to the questions in a way that returns you to your core message.

An example is, "All I know is that I'm here to stop the pain any way I can," or "My role is to heal, and what I am suggesting will contribute to the healing process."

O'Neill is the Executive Director of the Alcoholism and Drug Research Communications Center, a non-profit organization whose aim is to improve the flow of scientific information between researchers, health professionals and others concerned with the national effort to conquer alcoholism and related diseases. Since August 1990, he has published *Science Matters*, a monthly newsletter ($35/year) in which he and Carlton Erickson, PhD, "translate" articles and information from the medical/scientific literature into lay language to make it more accessible for use in talks or interviews. He recommends a book by Barbara Gastell, MD, *Presenting Science to the Public*, available from Williams and Williams Publishers (1-800-638-0672).

For more information, contact O'Neill at the Alcohol and Drug Research Communications Center, 4314 Medical Parkway, Austin, TX 78756; (512) 453-7388. □

A Book Review

The Natural History of Alcoholism

George E. Vaillant
Cambridge, Massachusetts: Harvard University Press, 1983.

The absence of a firm scientific foundation for treatment is one of the most frustrating aspects of working with alcoholics and addicts. It's true, we have a good deal of pharmacological information and even some neurochemical correlates of behavior, but they are not the whole story. Helping people through withdrawal and the initial stages of sobriety isn't that difficult. The really hard part of treating alcoholics and addicts is guiding them into long-lasting recovery—especially when they lack family, job and sober friends.

. . . the first scientific data to support what we've intuited clinically for a long time

This limitation in our understanding of the addictions was brought home several years ago at a California Society conference session on treatment outcome. William Miller, PhD, of the University of New Mexico, presented incontrovertible evidence that some alcoholics do indeed return successfully to controlled drinking. His data struck at the very foundation of the Twelve-Step based, abstinence-oriented inpatient programs that had brought many of us into the field. One of the moderators of the session, noting his own "addiction" to the belief that abstinence was an absolute requirement for successful recovery, took the microphone and announced to gales of chagrined laughter, "Hello. My name is Bill H., and I'm a medical director . . ."

But Bill needn't have felt so humbled. The history of medicine is full of cases in which scientific verification lags far behind successful "folk" treatment of illnesses. Long before digitalis was isolated, people with dropsy were benefitting from ingesting a foxglove leaf each day. It seems analogous that, despite our lack of solid evidence, most front-line clinicians are convinced that long-term recovery from alcohol or drug dependence is based upon abstinence, and that a maturing participation in the Twelve-Step program of Alcoholics Anonymous is the most reliable way to achieve and maintain it.

I suspect that our science frustrates us because so much of it is flawed. The majority of studies are retrospective or cross-sectional in design. Many have been performed on different populations and have used different or limited outcome measures. Most haven't been long enough or they suffer from inadequate follow-up methods. Some, such as studies of drinking in a laboratory setting, are ecologically irrelevant. Because it corrects nearly all these errors, *The Natural History of Alcoholism* is the standard against which most of our literature should be measured. Happily, it also provides the first scientific data to support what we've intuited clinically for a long time.

The book itself is based on three studies: a 40-year prospective evaluation (begun in 1940) of 400 inner-city men who entered the cohort as junior high school students; a second 40-year prospective examination of 200 men who entered the study as college sophomores; and an outcome study of 100 men and women followed for ten years after treatment at a Boston area detox center. The investigators were able to locate and perform in-depth assessments (including a wide range of psychosocial variables as well as drinking history) on virtually all of the original members of each group. The dropout rate was essentially nil.

To his great credit, author George Vaillant has combined sophisticated statistical analyses with both clear thinking and plain writing. In his introduction, entitled "The Problem," he lays out seven questions which weave their way throughout the body of the book:

clear thinking and plain writing

1. Is alcoholism a symptom, a social problem, or a disease?
2. Is alcoholism invariably progressive?
3. Are alcoholics premorbidly different from non-alcoholics?
4. Should abstinence be the primary goal of treatment?
5. Can "real" alcoholics return to social drinking?
6. Do current modes of treatment really alter the natural history of alcoholism?
7. How helpful is AA?

The answers, while not always definitive, do make sense and are accompanied by exemplary reasoning. Is alcoholism a disease? It depends upon what sorts of drinking problems you use to define it and how long you follow people – not to mention what other conditions you are willing to call diseases. Can alcoholics return to social drinking? While it appears that some people meeting criteria for the label "alcohol abuser" do return to non-problematic (though highly controlled) drinking, it is also clear that virtually no one who has become physiologically dependent controls their drinking for long. Is AA helpful? Almost none of the people who came into treatment with a poor prognosis (unemployed, without social support) did well *unless* they attended over 300 AA meetings.

These are only brief samples of the kinds of findings yielded by this extraordinary mass of data. Part I of the book, "What is Alcoholism?" takes up the variable appearance of alcoholism, its multifactorial etiology, and the natural history of the disorder. Part II characterizes the "Patterns of Recovery" by comparing alcoholics who became abstinent and those who did not. A second chapter in this section addresses the difficult question of those who return to asymptomatic drinking. In Part III, "Methodology," Vaillant provides us with a full disclosure of those in his study sample and the techniques used to assess them. And finally, in Part IV, he gives comfort to clinicians – "The Doctor's Dilemma" – and offers "Suggestions for Would-Be Helpers."

I don't wish to mislead anyone; *The Natural History of Alcoholism* is not a simple book. In its complexity, it reflects accurately a terribly difficult topic. At the same time, like working with the people it seeks to describe, returning to it again and again is immensely rewarding. □

Reviewed by Richard S. Sandor, MD

Editors' Note: Doctor Vaillant will speak at a symposium offered by the UCSF Department of Psychiatry on Saturday, April 25 from 8:00 am to 5:00 pm at Laurel Heights Conference Center, 3333 California Street, San Francisco. Admission is free. For information, contact Debra Moore at (415) 476-7520.

President's Column

The Dignity of Our Work

One of the disadvantages to a physician working in the addiction field is the scorn we occasionally experience from taking care of "those patients." The well-documented contempt that all too many physicians hold for alcohol and drug dependent patients is frequently displaced onto their caregivers. Two recent publications in the February issue of *JAMA* challenge this attitudinal problem. The first article by Walsh and co-workers from Boston demonstrated that 200 participants seen by a company EAP program, when warned about the negative effects of alcohol abuse, were much more likely to be abstinent and sober two years after that warning. The author felt that *the physician's warning alone* was an independent variable associated with a positive outcome at two years.

In an accompanying editorial, Thomas Delbanco, MD, of the Department of Medicine at Beth Israel Hospital in Boston writes eloquently of the advances that organized medicine is making in terms of curricula and faculty development in the area of drug and alcohol dependency. Delbanco also challenges the profession to have even less tolerance for the indifference and contempt directed by many physicians towards the addict in the past. I must admit I felt good about being a CSAM member after reading these articles. I encourage each of you to read them.

We owe a debt of gratitude to all the authors for these important articles. We as CSAM/ASAM members are uniquely qualified to join Delbanco in making this challenge. We must demand continued adherence to the highest scientific principles so we can continue to earn from our colleagues the respect our important work deserves. □

Kevin Olden, MD

1. Walsh, DC, PhD, Hingson, RW. The Impact of a Physician's Warning on Recovery After Alcoholism Treatment. **The Journal of the American Medical Association,** 267, (5), 663-672, 1992.

2. Delbanco, T, MD. Editorial: Patients Who Drink Too Much: Where Are Their Doctors? **The Journal of the American Medical Association,** 267 (5), 702-703, 1992.

NEWS ABOUT MEMBERS

Marilyn Vache is now the Medical Director of Chemical Dependency Services at El Camino Hospital.

Donald Dougherty is now the Medical Director of Scripps McDonald Center in La Jolla.

John Chappel received AMERSA's annual award for achievement in education about alcoholism and other drug dependencies.

Kevin Olden has opened a practice of gastroenterology and addiction medicine in San Francisco near St. Mary's Hospital.

William Brostoff begins on April 15 as Medical Director of Chemical Dependency Services at St. Mary's Hospital in San Francisco. **Gill Ayotte** will continue with the program as the Senior Medical Officer.

Mel Pohl has moved back to Nevada where he is the Medical Director of Substance Abuse Services for Behavioral Healthcare Options in Las Vegas. He continues as a Medical Advisor to Pride Institute.

Richard Sandor left the position of Physician Director of the Betty Ford Outpatient Center in Los Angeles when it closed; he maintains his private practice of psychiatry and his position as chief of the chemical dependence treatment programs at the Sepulveda VA.

Bill Shaw has moved from the Naval Hospital in Oakland to the Naval Branch Clinic at Mare Island where he has assumed duty as the Senior Medical Officer.

Kathy Unger is serving as a staff psychiatrist in the San Francisco Department of Public Health's Program of Health Care for the Homeless.

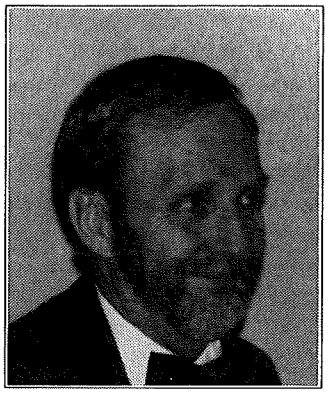
Leland Whitson is the new Chairman of the California Medical Association's Committee on the Well-Being of Physicians.

Westley Clark has been appointed to a three-year term on the National Advisory Council for NIDA, the National Institute for Drug Abuse.

Ronald Smith has accepted a three-year appointment at the National Naval Medical Center in Bethesda, Maryland. □

In Memorium

Ray Anderson, MD, died in March in New York where he had lived since moving there in 1986 to become the Medical Director of Arms Acres. His contributions to the field of addiction medicine were as a teacher and a clinician and a good friend to many.



For the California Society, he played several important roles. He took over the Chairmanship of the Committee on Education from George Lundberg in 1981 and led the Committee until 1986. During this time, the certification project was launched in California with exams in 1983 and 1984, and the first review courses were designed and given. He served on the Executive Council during that same period.

He chaired the Department of Family Medicine at UC Irvine for several years in the 1970s and remained an Associate Professor there when he left academia to take on the medical directorship of the inpatient treatment unit at Memorial Hospital in Long Beach until his move to New York.

He chaired the California Medical Association Committee on Alcoholism and Other Drug Dependencies.

He was very active with the American Academy of Family Physicians and the Society of Teachers of Family Medicine. He contributed chapters to several books on curriculum in chemical dependence for medical students and residents, as well as the first syllabus for the American Society of Addiction Medicine.

He is survived by four children, who ask that any donations in Ray's memory be made to the Ruth Fox Foundation, ASAM, 12 West 21st Street, New York, NY 10010. □

Applicants For Membership

The names of applicants are published and sufficient time is allowed for comments from the members before the Executive Council acts to accept them as members. If you have comments to bring to the attention of the Executive Council, please contact Kevin Olden, MD, at (415) 668-1001, or write to him in care of the California Society office.

Linda Grissino, MD, is an addiction medicine fellow at Loma Linda University Medical Center, and the Medical Director of the Clearview Addiction Recovery Program's Center for Health Promotion at Loma Linda University Medical Center. Doctor Grissino graduated from New York University in 1983 and completed a residency in general preventive medicine and public health at Loma Linda in 1991. She is a Clinical Instructor in the Department of Preventive Medicine and the School of Public Health at Loma Linda.

John Lynch, MD, is a board-certified gynecologist in private practice with the FACEY Medical Group and consultant to the substance abuse department at Holy Cross Hospital. He graduated from Georgetown University in 1956 and completed a residency in obstetrics-gynecology there between 1968 and 1961. He is chairman of the Impaired Physicians Committees at Holy Cross Hospital and for District 17 of the Los Angeles County Medical Association. He is Associate Clinical Professor at the University of Southern California, Los Angeles County Hospital.

John J. McCarthy, MD, a board-certified psychiatrist, is Medical Director of Bi-Valley Medical Clinic, a methadone maintenance program in Sacramento. He graduated from Tufts University Medical School in 1969. He completed a residency in internal medicine at Los Angeles County Hospital in 1971 and a residency in psychiatry at the University of Colorado Medical Center in 1975. He is Associate Clinical Professor of Psychiatry at the University of California, Davis.

Other applicants include:
Robert Belknap, MD, Mill Valley
Darryl Brown, MD, Long Beach
Laurence Denny, MD, Encinitas
L. Arden Gifford, MD, El Paso, TX
Howard Kornfeld, MD, Mill Valley
Germaine Strother, MD, Canyon Crest □

WORK GROUPS ARE FORMING

New committees and work groups are forming. Members who would like to participate are invited to call the Chair or the California Society offices at (415) 428-9091.

The Chemically Dependent Physician

Gary Levine is convening a work group on the chemically dependent physician. The first activity will be to agree on a definition of effectiveness for hospital medical staff committees on the impaired physician. Other projects will be considered as members of the work group propose them. Contact him at (415) 383-2991, or contact the California Society.

The Committee on the Scope of the Field of Addiction Medicine

This new committee has been asked to prepare a paper which examines issues related to the boundaries of the practice of addiction medicine. When it established the committee, the Executive Council agreed that the paper is expected to identify and present the issues with sufficient background and scholarship to provide the foundation for a position statement. The approach which the committee will take is described in detail in the Open Letter to CSAM Members on page 6 of this issue of NEWS. The Chair is Timmen Cermak; contact him at (415) 346-4460, or contact the California Society office.

The Medical Review Officer (MRO)

Westley Clark, a member of ASAM's MRO Committee, is convening a study group on MRO issues. Among the first activities will be cooperation with the ASAM MRO Committee in co-sponsoring an MRO Training Conference to be given in San Francisco, October 15-17. Contact Westley Clark at (415) 750-2127, or contact the California Society office.

Methadone Treatment

A Study Group on Methadone Treatment is forming. The first project is to design a conference for physicians in methadone maintenance treatment programs and physicians who treat patients who are maintained on methadone. Contact Gail B. Jara at the California Society office, (415) 428-9091.

Family and Generational Issues

Tim Cermak, who chairs the ASAM Committee on this subject, is convening a CSAM study group on family and generational issues. Contact him at (415) 346-4460, or contact the California Society office. □

CONTINUING MEDICAL EDUCATION

Clinical and Research Advances in the Treatment of Alcoholism and Drug Abuse

Laurel Heights Conference Center, 3333 California Street, San Francisco
Saturday, April 25, 8:00 am to 5:00 pm
Sponsored by the Department of Psychiatry, University of California, San Francisco
Speaker: George Vaillant, MD
Fee: $8 for CME credit; otherwise, no fee
For information, contact Debra Moore, 415/476-7520.

Two conferences sponsored by Haight Ashbury Free Clinics; co-sponsored by ASAM and Cambridge Institute

Treatment and Prevention in the Era of Smokeable Drugs, June 4-5

Miyako Hotel, San Francisco
Speakers include David Smith, MD; Max Schneider, MD, CADC; Donald Wesson, MD; Karen Sees, DO; Kenneth Blum, PhD; Andrew Mecca, DrPH; John Newmeyer, PhD; Darryl Inaba, PharmD; Edgar Adams, ScD
Fees: $195; two or more registering together, $145; student/intern/resident, $145; Senior, $145; one-day, $100
Credit: 11.5 hours

Prescribing Controlled Substances in the '90s, June 6-7

Speakers include David Smith, MD; Sidney Schnoll, MD, PhD; Paula Horvatich, PhD; H. Westley Clark, MD, JD; Bernard Baumrin, PhD, JD; Edgar Adams, ScD
Fee: $295
Credit: 12.5 hours
For information, call Haight Ashbury Training; 415/565-1902.

ASAM 2nd National Conference on Adolescent Addiction

Hilton Placio Del Oro, San Antonio, TX
June 25-28
Fees: ASAM members, $290; non-members, $350; non-physician, $200; medical student, $50
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

ASAM Medical Review Officer Training Seminars
Crystal Gateway Marriott, Arlington, VA
July 17-19

The Basics of Being an MRO: The Art and Practice of the MRO

Friday morning, July 17
Fee: $75
Credit: 2.5 hours
Speakers are Ian MacDonald, MD; MP George, MS, of Smith Kline Beecham Clinical Laboratories

MRO for the Experts: The Science, Rules and Art of Medical Review

Friday afternoon to Sunday, July 17-19
Fee: $350
Credit: 14.5 hours
Speakers include Ian MacDonald, MD; Robert Willette, PhD; J. Michael Walsh, PhD; David Smith, MD; Robert DuPont, MD; Mark Upfal, MD; H. Westley Clark, MD, JD
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

ASAM 5th National Conference on Nicotine Dependence

Seattle Sheraton, Seattle, WA
September 17-20
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.
