CSAM NEWS

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INSIDE

Spirituality and Addiction Medicine: Does Spirituality Have a Place in the Practice of Addiction Medicine?

Richard S. Sandor, MD

This November at our annual meeting, CSAM sponsored a preconference workshop on just this question and, although the workshop was oversubscribed and rated very highly by the participants, other CSAM members objected to our support of this discussion. The protest is not new. Eugene Schoenfeld, MD, first spoke out in 1985 when CSAM sponsored a conference entitled "Competition and Cooperation between 12-Step Groups and Psychotherapy." In 1990, he joined with Albert Ellis, PhD, in publishing the article "Divine Intervention and the Treatment of Chemical Dependency" in the *Journal of Substance Abuse*. In the same issue several noted clinicians and academics offered editorial commentary, and Schoenfeld and Ellis rebutted. In the hope of stimulating further discussion of this important matter, we have reprinted excerpts from the article, the commentary and the reply.

It seems all the more important to continue the discussion at this time in view of the promotion of Rational Recovery (RR) as an alternative to Alcoholics Anonymous (AA). Even physicians who have no particular personal experience with AA will need to understand what this controversy is about in order to respond intelligently to their patient's questions and needs.

It would be nice if the controversy over spirituality were merely a matter of semantics. Schoenfeld and Ellis seem to suggest as much when they comment that it is better "to instruct patients that there are outside powers who can help restore one to sanity, not necessarily higher powers, but *other or different powers*" [italics mine]. And again, in criticizing the language of Step 12, they note that "while a person may have had a *philosophical* [italics mine] awakening as a result of taking AA's 12 steps, calling this spiritual is unscientific and antitherapeutic." I suspect there is an element of disagreement based on this "confusion of tongues"; however, it is not the whole story. The conflict is much deeper, more complex, and older.

Barry Rosen, MD, who organized the workshop this November, noted at the meeting that the friction between science and reli-

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gion had all the characteristics of child-parent conflict. While it is true that the scientific tradition grew out of and later opposed the religious hegemony of the Middle Ages, the battle between science and religion as expressed in the debate over spirituality seems less a confrontation between father and son than a dispute among

We will need to understand this controversy in order to respond intelligently to our patient's questions and needs.

competitors. Although Ellis and Schoenfeld claim "We shall not argue the merits of one set of religious beliefs over another," in the next paragraph they write ". . . we also *believe* [italics mine] that even more millions of addicts have turned away from AA because of its sectarian emphasis on Higher Power." Both their article and their editorial reply are rife with unsubstantiated claims, beliefs, thoughts, and opinions. This sort of belief system masquerading under the name "science" has all the characteristics of a religion itself. It has been called by some "Scientism."

What is being defended in scientism is not hypothesis and experimental trial, but a reductionist and materialist twist on the Humanist tradition. Stated in its baldest paradox, people who hold the sorts of views Schoenfeld and Ellis espouse make several assumptions which they believe are not beliefs. David Ehrenfeld, in his brilliant essay, *The Arrogance of Humanism*, exposes the subtle set of presumptions underlying the worst in modern rationalism — assumptions upon which the work of many psychologists and psychiatrists rests:

> Humanists are fond of attacking religion for its untestable assumptions, but humanism contains untestable assumptions of its own. These are the givens, the things that are unconsciously assumed and rarely or never debated. If they occurred in others, humanists would call them superstitions, or, more politely, articles of faith. . . .
>
> All problems are soluble by people.
>
> Many problems are soluble by technology.
>
> Those problems that are not soluble by technology, or by technology alone, have solutions in the social world (of politics, economics, etc.).
>
> When the chips are down, we will apply ourselves and work together for a solution before it is too late.

It is vitally important to recognize that many of the solutions to modern problems have been made necessary by earlier solutions to earlier problems which in turn were earlier solutions. And so on. Again, Ehrenfeld says it succinctly:

> The society clever enough to perform sophisticated research on cancer is the society clever enough to invent the sugar substitutes, children's sleepwear ingredients, food coloring agents, and swimming pool test kits that may cause it.

From this point of view, then, we need to be very careful in approaching the treatment of addictive disorders. From a very broad perspective most of the addictive disorders can be thought of as man-made. Psychoactive substances in their natural forms have been used by native peoples for centuries. Their use is wrapped in elaborate, socially circumscribed rituals which are woven into the sacred traditions of the culture. We moderns, on the other hand, have reduced our interest in these practices to the "active ingredients" (from opium, morphine; from coca leaves, cocaine) — discarding the rituals and traditions of their use as irrelevant. It was Rhazes, a Persian *physician*, who first distilled alcohol from grain ferments. Both tobacco and cocaine were first extolled by the *physicians* Nicot and Freud. The technology of hypodermic and intravenous injection did not grow on trees. It takes only a slight stretch of the imagination to think of the origins of addictions as something akin to iatrogenic. I'm not suggesting any action needs to be taken. I merely want to point out that for all our vaunted "progress," we have created some genuinely terrible problems.

I am beginning to suspect that there isn't anything accidental about this state of affairs — that the AA expression of the law of karma, "what goes around comes around," is truer than we would like to believe. Could it be that the act of isolating these potent chemicals from their context (again, in the broadest sense) is the very act which also leads to the isolation of the addict? If it is true, then this controversy is less a matter of words than a reflection of the modes of consciousness in which they arise.

Many terms have been used to describe different levels or modes of consciousness and

there is considerable confusion on that account. For our purposes, the words "rational" and "spiritual" will serve to distinguish the two at issue here, although some would prefer to call the latter "transcendent" or "transpersonal." The rational is above all a mode of action, explication, knowledge, argument, manipulation, and of external verification. On the other hand, the spiritual is receptive, perceptive, narrative, contemplative, ineffable, and verified internally. It seems to me that the central message of AA is that rational and spiritual modes of consciousness stand in hierarchical relation to one another, and that the spiritual encompasses the rational and not *vice versa*. This idea cannot be dismissed as an expression of religious wish-fulfillment. It is a view held by prominent and responsible 20th century students of psychology. The ideas of both William James and Carl Jung played major roles in the development of AA.

If AA does anything, it provides a way for people to rediscover this non-rational mode of consciousness. It appeals not to external experts in "the latest" information, but rather to the mysterious source of one's own experience. It calls to authorship of one's life, not absolute, independent control. Having suffered the consequence of "better living through chemistry," alcoholics and addicts find that the way out is not more of the same, however rationally it is dressed up, but of something quite different. And not merely "other" or "different," but experienced as higher. It compels not through force, but through what many feel as love.

The search for this higher consciousness is the aim of all spiritual traditions, and it is not found through passivity. It must be paid for in acts of humility and honesty. If Ellis and Schoenfeld are correct in anything, it is in calling attention to the real danger of losing contact with the original message of AA. Its most sublime features, perhaps because they are so alien to the modern way of living, could easily disappear into what Chogyam Trungpa has called "Spiritual Materialism":

> Walking the spiritual path properly is a very subtle process; it is not something to jump into naively. There are numerous sidetracks which lead to a distorted, ego-centered version of spirituality; we can deceive ourselves into thinking we are developing spiritually when instead we are strengthening our egocentricity though spiritual techniques.

I hope I'm not alone in wincing when hearing people speak offhandedly about "my" higher power — as though something larger now belonged to them. Perhaps it isn't what they mean, but the drift is in the wrong direction. The same can be said for the spiritual principle of anonymity — it is not merely the non-professional's version of confidentiality. It is an important means of minimizing egoism.

I'm afraid some of this deterioration may already be taking place. Many individuals in or sympathetic to the AA movement have become just as vehemently anti-scientific as Ellis and Schoenfeld are anti-spiritual. How many of us have watched patients suffer needlessly from eminently treatable episodes of depression or panic attack because someone in AA told them that antidepressants were "mood-altering" chemicals and to take them would be violating their sobriety? The spiritual path leads to wisdom, not dogmatism.

Clearly, this editorial is only an introduction to very large questions, and the intention in creating this issue of the *NEWS* was to stimulate further discussion of spirituality in addiction medicine. If nothing else, the workshop at our annual meeting demonstrated that many physicians, recovering and non-recovering alike, are deeply interested in these questions. We hope to hear from our members, both in subsequent issues of the *NEWS* and in future conferences. □

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Divine Intervention and the Treatment of Chemical Dependency

Albert Ellis and Eugene Schoenfeld

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Alcoholics Anonymous is the predominant influence on drug abuse treatment programs in the United States today. Central to the philosophy of Alcoholics Anonymous and related "12-step" groups is the concept of Divine Intervention by a Higher Power. The use of specific religious beliefs as a major component of recommended treatment is singular to this therapeutic field. We will demonstrate the strong religious content of the AA program and explain why AA became the major mode of treatment for chemical dependency in this country. We will also give our opinion of the benefits and problems presented by AA for people recovering from alcoholism and other drug addictions. Finally, based on our years of observing, studying, and treating these problems, we will suggest modifications which might allow more people access to the many helpful aspects of AA. We shall not argue the merits of one set of religious beliefs over another. A discussion of that sort more properly belongs in the realm of theology. But we shall question the propriety of combining any religious philosophy with the treatment of alcoholism and other drug abuse problems.

For many years, Alcoholics Anonymous and related "12-Step" groups, such as Narcotics Anonymous, Cocaine Anonymous, Overeaters Anonymous, Overspenders Anonymous, Gamblers Anonymous, and others have been in the forefront of providing a concrete philosophy and treatment to aid victims of addictive diseases. We believe that since its founding in 1935, Alcoholics Anonymous has helped millions of addicts. But we also believe that even more millions of addicts have turned away from AA because of its sectarian emphasis on Higher Power.

As early as 1966, it was found that Alcoholics Anonymous was used as a primary therapy in 88% of surveyed hospitals treating alcoholism (Moore & Buchanan, 1966). That figure is even higher today given the explosive growth of chemical dependency treatment centers in recent years, and the consequent demand for addiction counselors to work in these centers. The relatively sudden need to employ addiction counselors far exceeded the capability of university programs to develop curricula and graduate sufficient numbers of academically qualified individuals. Until recently, training programs for chemical dependency counselors were rarely found. Chemical dependency counselors were then, and are now, likely to be persons recovering from alcoholism or other drug addictions who had received help for their life-threatening problems through AA. Reinforced by its religious content, they often believe 12-step programs are the only way addicts can overcome their disorder. Naturally then, the treatment they provide is consistent with and promotes the philosophy of Alcoholics Anonymous, a program they not only know best, but may believe in with religious fervor. As a result, the ideology and methodology of AA now dominates the field of chemical dependency treatment.

The California Society for the Treatment of Alcoholism and Other Drug Dependencies (now the California Society of Addiction Medicine) is an organization for physicians working in the field of chemical dependency treatment. In October 1985, this group held a conference in Los Angeles dealing with Alcoholics Anonymous and its allied groups. The opening sentence from the brochure describing this conference read: "A central goal of chemical dependence treatment is to introduce patients and their families to the 12 Step concept of recovery and to motivate them to membership in Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Al-anon, or Adult Children of Alcoholics" (California Society, 1985). Organizations that seek approval from members of Alcoholics Anonymous and related groups do so for both benevolent and pragmatic reasons. For example, hospital-based chemical dependency treatment programs work hard to create good will among 12-step programs not only because they are felt helpful to recovering alcoholics and other addicts, but because they aim to solicit referrals.

The Twelve Steps of Alcoholics Anonymous

Table 1 presents the 12 Steps of AA. It is apparent that six of the steps make reference to a particular notion of God reflecting the origins of AA in an English Protestant sect called the Oxford Group. Traditionally, the 12 Steps are followed in order. We shall briefly discuss each of these steps, giving our opinion of their therapeutic benefits and drawbacks.

Step 1: "We admitted we were powerless over alcohol (or drugs, gambling, sex, etc.) – that our lives had become unmanageable." We agree with Alcoholics Anonymous that acceptance of Step 1 is vital if an individual is to overcome an addiction. . . .

Step 2: "Came to believe that a power greater than ourselves could restore us to sanity." Step 2 and the other steps referring to God cause most of the difficulty with people becoming further involved with AA programs. In such cases, AA-oriented counselors may try to explain away the Higher Power concept as something other than what it plainly is, an invocation of Divine Intervention. They may tell group members troubled by this concept that the Higher Power can be the Alcoholics Anonymous group, or the treatment facility, or something within the person. But Higher Power is always in capital letters. There is no mistaking its meaning. Many people, of course, believe along with AA that a Higher Power exists and that He, She, or It responds to people's wishes and prayers. But we think such theological hypotheses are not the proper concern of a therapeutic treatment team, with the possible exception of a minister of the patient's faith. We strongly believe that telling patients they can only recover through the direct intervention of a Higher Power is often destructive to the treatment process. It perpetuates the idea that the person is helpless, powerless, and will always remain that way. Were it proper for us therapists to be promulgating religious teachings, we would prefer something like, "God helps those who help themselves." But therapists do not usually invoke religious dogma and we do not think the teaching of religious beliefs is the proper purview of a treatment team dealing with a broad range of patients, most of whom have widely different religious views and many of whom are nonreligious.

Alcoholics Anonymous has literature directed toward agnostics and atheists, literature which states that these nonbelievers will eventually come around to accept the AA religious program (Alcoholics Anonymous, 1976). The kind of Divine Intervention proposed in half of the 12 Steps is objectionable not only to agnostics and atheists, but also to followers of many religions. . . .

Most people have a concept of God, religion, and spirituality based on the way they were raised. Since they are often locked into their belief systems at a relatively early age, arguing issues of God and religion is usually a waste of time and energy. No matter how they reach a decision, usually by adolescence, on where we came from, where we are going, and what (if anything) it all means, they rarely change their basic beliefs unless convinced by startling new evidence, or more likely, religious conversion at times of psychological duress. Individuals requiring treatment for substance abuse problems are certainly undergoing psychological duress. That is why AA teaches that if agnostics and other non-Believers are humored, are told that the Higher Power doesn't really necessarily mean God, eventually they will come to believe the religious teachings of AA (Alcoholics Anonymous, 1976).

A person may be so desperate and beaten that his or her normal beliefs can be temporarily suspended, as in "there are no atheists in foxholes." Yes, the drowning may grasp at any straw. But one of the present aims in chemical dependency treatment is to reach out and catch people before they hit bottom. Yes, you can get a deist, or agnostic, or atheist or member of an Eastern religion to recite Christian prayers, when the options offered seem like life or death. But then you've not only sabotaged part of their faith, but part of their self-acceptance as well. . . .

We think it much more useful and universally applicable to instruct patients that there are outside powers who can help restore one to sanity, not necessarily higher powers, but other or different powers. That, we tell them, is why we consult physicians when we are ill, mechanics to repair our vehicles, plumbers to repair a broken faucet, and therapists for drug abuse problems. They have specialized knowledge not possessed by everyone. Their powers are not Higher or supernatural, but other or different. Few people have their religious or spiritual beliefs violated or demeaned by asking for this kind of help. But for many the concept that help is found only through the intervention of a Higher Power is false and unacceptable. And it may easily undermine their confidence to change and control themselves.

Step 3: "Made a decision to turn our will and our lives over to the care of God as we understand him. . . ." To a person who doesn't share this particular religious concept, Step 3 further weakens the idea of self-will. Alcoholics and other addicts need to learn that they *can* with hard work and practice, significantly change their lives, and not believe that they are such weaklings that *only* a supernatural being or force can help them.

Step 4: "Made a searching and fearless moral inventory of ourselves." This seems to us a useful step for everyone, addicted or not. And it preferably should be practiced regularly.

Step 5: "Admitted to God, to ourselves, and to another human being the exact nature of our wrongs." "Wrongs" may be subject to many interpretations, but it is surely useful to speak of one's troubles and doubts openly and completely to another person. In doing so, of course, things are revealed which might not otherwise come to conscious attention. But many individuals think it foolish to believe that God, the Ruler of the Universe, has nothing better to do than to listen all day and night to their personal recitation of wrongdoings. . . .

(continued on p. 6)

Divine Intervention *(continued)*

Step 6: "Were entirely ready to have God remove all these defects of character." For many years, alcoholism has been considered a disease. Other drug dependencies are also now so classified. But even if addictions were "defects of character," should they not be resolved by effort on the part of the addict? After all, one of the basic problems of addicts is that they depend on something outside of themselves (excessive amounts of drugs, food, gambling, etc.) to make themselves feel better. This Step reinforces that kind of dependency. Several schools of psychotherapy, such as rational-emotive therapy (RET) and cognitive-behavioral therapy (CBT), teach individuals with "character defects," including addicts and compulsives, that it is very difficult but hardly impossible for them to change themselves. They are shown how to decrease their dependency, reduce their self-damning and low frustration tolerance, and increase their powers of self-determination and self-control (Ellis, 1962, 1985a; Ellis & Dryden, 1987; Ellis & Grieger, 1986; Ellis, McInerney, DiGuiseppe, & Yeager, 1988). Alcoholics Anonymous's reliance on a supernatural Higher Power shows no confidence in the ability of addicts to abet their own growth and development and to help themselves.

Table 1: The Twelve Steps
(From Twelve Steps and Twelve Traditions, Alcoholics Anonymous World Services, Inc., New York, 1982)

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11 Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Table 2: Skinner's Humanist Alternative 12 Steps
(From B.F. Skinner's "A Humanist Alternative to AA's Twelve Steps," The Humanist, Volume 5, July/August, 1977)

1. We accept the fact that all our efforts to stop drinking have failed.
2. We believe that we must turn elsewhere for help.
3. We turn to our fellow men and women, particularly those who have struggled with the same problem.
4. We have made a list of the situations in which we are most likely to drink.
5. We ask our friends to help us avoid those situations.
6. We are ready to accept the help they give us.
7. We earnestly hope that they will help.
8. We have made a list of the persons we have harmed and to whom we hope to make amends.
9. We shall do all we can to make amends in any way that will not cause further harm.
10. We will continue to make such lists and revise them as needed.
11. We appreciate what our friends have done and are doing to help us.
12. We, in turn, are ready to help others who may come to us in the same way.

Step 7: "Humbly asked Him to remove our shortcomings." When members of Alcoholics Anonymous protest that the Higher Power concept need not refer to a God figure they are forgetting some of the Steps, including this one. For alcoholics to "humbly" ask God to remove their shortcomings seems to us self-denigrating, a real cop-out.

Step 8: "Made a list of all persons we had harmed and became willing to make amends to them all." This would be a useful practice for anyone. . . .

Step 9: "Made direct amends to such people wherever possible, except when to do so would injure them or others." The steps which don't deal with AA's concept of God seem universally applicable and useful. This is an illustration of the wisdom of those who founded AA.

Step 10: "Continued to take personal inventory and when we were wrong promptly admitted it." Another useful practice for any individual, addicted or not.

Step 11: "Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out." Again, this is a specific religious principle, suitable for church observances or personal religious practices. It clearly states that addicts have no power other than the power to carry out God's will – that they have no power of their own!

Step 12: "Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs." Helping other addicts helps the individual recovering from the same problem. But while a person "may well have a *philosophic* awakening as a result of taking Alcoholics Anonymous's 12 Steps, calling this a "spiritual" awakening is unscientific and antitherapeutic. "Spiritual" is a vague word that means anything from intellectual and philosophical to incorporeal, sacred, and ecclesiastical. Many people who have a profound philosophical and intellectual awakening and have thereby quit drinking have been distinctly agnostic, atheistic, and not at all "spiritual" (Ellis, 1985b, p. 96).

While Alcoholics Anonymous and its related groups have surely helped millions of drug abuse victims, we believe more harm than good is caused by its insistence that the concept of Divine Intervention be maintained as part of its program. There are individuals who insist that AA does not promote religious concepts, only "spiritual" ideas. But no literate person reading the 12 Steps can misunderstand their religious meaning or intent.

AA in Treatment Programs

A related problem involves the use of AA in public treatment facilities, which seems to be a violation of constitutional guarantees separating Church from State. Nonprofit institutions using the religious precepts of AA as part of their treatment program threaten their tax-exempt status. When sectarian religious beliefs are mandated by law, or supported by government funds, by state-supported facilities, or by state-appointed functionaries, there is a clear violation of the enlightened precepts on which this country was founded. In one case, a patient at the Denver Veterans Administration hospital was told he had to attend AA meetings in order to remain in the treatment program. He sued in Federal Court and won a settlement. As a result, VA hospitals now carefully instruct their personnel that attendance at self-help groups such as Alcoholics Anonymous is recommended, but not mandatory (Hughes, 1984). Although we are no more attorneys than we are theologians, we believe it is clearly unconstitutional for a judge to include mandatory attendance at 12-step meetings as part of a sentencing process, due to the religious content values of most of the steps. Do not mistake our intent. We are convinced of the value of self-help groups in the continuing recovery of chemically dependent and other individuals. We see great benefit in the nonreligious steps of AA. But we see real harm in retaining those steps dealing with the AA concept of God.

Do not mistake our intent. We are convinced of the value of self-help groups in the continuing recovery of chemically dependent and other individuals. We see great benefit in the nonreligious steps of AA. But we see real harm in retaining those steps dealing with the AA concept of God.

A Humanist Alternative

Psychologist B.F. Skinner also has some serious objections to the religiously oriented AA steps. Skinner wrote a Twelve-Step Humanist alternative program, which he sent to AA for their consideration. They informed him that it would be impossible to change their version and their practices without a major vote of all AA members

(continued on p. 8)

(Skinner, 1977). Skinner's Humanist Alternative proposed Steps are listed in Table 2.

The Alcoholics Anonymous steps involving a higher power are clearly religious principles. There is not reason to believe that removing or replacing these steps would worsen the dismal recovery rate in alcoholism treatment programs. Many people turn away from 12-step programs because of their religious principles. Moreover, the founders of AA never intended that their program would provide the content for treatment in hospital and other residential care facilities.

Since this article was originally written, a number of groups have been organized, such as the Secular Organization for Sobriety (SOS) and Rational Recovery (RR).

A common response to our arguments against Alcoholics Anonymous religiosity is the suggestion that alternative self-help groups be formed. Fine. Since this article was originally written, a number of groups have been organized, such as the Secular Organization for Sobriety (SOS) and Rational Recovery (RR). However, thousands of 12-step programs meet daily throughout this country, indeed throughout the world. Alcoholics Anonymous has the potential to provide a service consistent with the dreams of its founders, who were true visionaries. They believed that AA should be amenable to change. One of the most common slogans now heard at AA meetings is, "If it's not broken, don't fix it." But the discouraging success rate of chemical dependency treatment cries out for something to be fixed. As we approach the beginning of the 21st century is it not time to place the doctrine of Divine Intervention back in the churches?

Religions are among those institutions least amenable to change, usually because followers believe the precepts of their religion are absolute truth, originating in God's true word, often through visions reported by mortals. Are Alcoholics Anonymous and related groups capable of making fundamental changes in their programs? Like giving up teaching that dependence on a Higher Power is necessary for recovery? 12-step programs are presently religious sects with a focus on addictions. Churches are the proper forum for instruction in fixed religious beliefs, not hospitals and clinics. □

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Editors' Note: The same issue of the Journal of Substance Abuse *included comments from several people who had read the Ellis and Schoenfeld article before publication. Doctors Ellis and Schoenfeld in turn wrote replies. The comments and replies are excerpted on the following pages.*

COMMENTARY and REPLY

From Mark Keller
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My first reaction is that the authors' belief that "millions" have rejected AA because of its Higher Power emphasis is only a *belief*. Even if this belief should be as valid as the popular belief in God, a mere belief can hardly counter the fact, noted by the authors, that AA, as it is, has helped millions.

Most of all, I am surprised by the authors' assumption that because many have turned away from AA, that fellowship should abandon its traditional emphases. (How many therapies do they know – behavioral psychology? psychoanalysis? holistic psychiatry? – from which numerous patients have not turned away?) They seem to imply that if AA would change its 12 Steps to a purely Skinnerian-humanistic dozen, all those unconverted alcoholics would no longer turn away.

Undoubtedly, many alcoholics are put off by the spiritual or religious or God-ful aspects of AA. They are not without recourse, however. They can go into a despiritualized treatment program. Some can even go to Drs. Ellis and Schoenfeld. The fact is, however, that many addicts are turned off by psychology and psychiatry. Some of those go into AA and there achieve remission. Indeed, it is likely that the statistical claims of success in any treatment or program are only partly valid. This has been my observation during more than 50 years: that a patient A, who fails in Program X, then succeeds in Program Y, while a patient B who fails in Programs X and Y, then succeeds in treatment Z. AA, with its spiritual program, does not succeed with every alcoholic; nor do Ellis and Schoenfeld. The failures in each may achieve remission in the other. It is therefore illogical to argue that a particular program with acknowledged millions of successes should change its method.

Doctors Ellis and Schoenfeld reply

Dr. Keller points out that AA is only one program for alcoholics and therefore does not have to change its ways, any more than different psychotherapeutic systems have to change theirs. But the drug abuse treatment field is almost exclusively dominated by the members and teachings of AA, for reasons elucidated in our paper.

Most major therapies today have become less sectarian with time, more integrated and eclectic. Even psychoanalysis, one of the most rigid therapeutic systems, has now adopted object relations and self-system theories and practices. It would certainly be nice if AA became more integrative and eclectic, too, for our own observations have convinced us that support groups can provide loving care and valuable insights. We would like more people to benefit from support groups – in most parts of the country the only such groups are AA and related 12-Step programs. Their sectarian religious teachings, with associated slogans and jargon, dissuade many needy alcoholics and addicts from attending, while discouraging innovative thought within the program.

We do agree with Dr. Keller on one point. Many kinds of support groups should be available to alcoholics and other substance abusers. Recently formed secular groups include Secular Organizations for Sobriety (S.O.S., or Save our Selves) and American Atheists' Addiction Recovery Groups. At least one of us particularly favors Rational Recovery (Box 800, Lotus, CA 95651), which includes the theory and practice of Rational-Emotive Therapy (R.E.T.). But our preferred alternative would be to see Alcoholics Anonymous become less sectarian because that organization is much older, more experienced, more popular, and better established than these new support groups.

From Barbara McCrady
The Center of Alcohol Studies
Rutgers – The State University of New Jersey

I fully agree with Ellis and Schoenfeld's analysis of AA as representing a traditional, Christian view of God. However, they suggest that this is inappropriate, and that AA could just eliminate the God part and be an even better program. While this ultimately is an empirical question, they appear to ignore the basic theoretical assumptions of AA in making such a suggestion. AA views alcoholism *primarily* as a "spiritual disease." The emphasis of AA is not on physiological dependency, poor marital or family relationships, or disrupted social functioning. The emphasis of AA is on internal loss of faith, hope, and spirituality as the core of alcoholism. Viewed in this light, the program just offer spiritual solutions or spiritual guidance to be consistent with its own view of the problem.

A final important point is Ellis and Schoenfeld's suggestion that AA fosters dependency rather than self-reliance. Reading AA literature and examining the AA steps certainly suggests the importance of giving up self-control and self-reliance, and turning instead to the will of God. My personal experience with long-term members of AA, though, seems contradictory to this view. Many AA members seem to experience a strong sense of personal control, self-reliance, and self-esteem, seeming to derive personal strength from their support. Many of these people are decidedly *not* passive. Without data to inform us, though, we can only engage in theoretical discussions about whether AA decreases or increases an individual's sense of self-control.

Doctors Ellis and Schoenfeld reply

Dr. McCrady points out that AA views alcoholism primarily as a "spiritual disease," and therefore "must offer spiritual solutions or spiritual guidance to be consistent with its own view of the problem." But we are arguing that the AA view of "spirituality" is one-sided and sectarian and preferably should be changed.

But we are arguing that the AA view of "spirituality" is one-sided and sectarian and preferably should be changed.

From John N. Chappel
University of Nevada School of Medicine
Reno

AA does not meet any of the modern criteria for religion. The only requirement for membership is a desire to stop drinking, which has nothing to do with religion (Alcoholics Anonymous, 1976). There is not creed, dogma, or theology to be learned with accompanying ceremonies for joining. AA is not in competition with any other religion. It is not unusual for AA members to belong to a Christian, Moslem, Buddhist, or other religion, or to have no interest in any religious affiliation. Further evidence that AA is not a religion is that it is compatible with every known religion. The Roman Catholic church investigated AA because the first meetings were held in conjunction with the Oxford Group, which was Protestant. Membership in AA was approved as compatible with membership in the Roman Catholic church (Kurtz, 1979). This approval does not appear to have been given for any existing religion. There are no Muslim Catholics, Protestant Catholics, or Hindu Catholics, but there are Muslim AAs, Catholic AAs, Hindu AAs, as well as atheist AAs. It was from the demonstrated failure of the Oxford Movement in helping alcoholics, that the founder of AA learned

to excise religion, but leave the benefit of spiritual experience (Kurtz, 1979).

Further evidence that AA is spiritual and not religious is that atheists and agnostics can work comfortably with AA once they understand the need to acknowledge something other than themselves, or other humans, which can help the healing process. Atheist medical students and physicians understand Pare's statement, "I merely dress the wound, God heals it." This is a simple acknowledgement that there are aspects of ourselves and the world which are not accessible to scientific research or the experience of our five senses. How are we to acknowledge the fact that some creative force beyond our limited comprehension created the world and is present in it? The genius of the 12-Step program is that the acknowledgement is made in the absence of any attempt to describe or explain what that force or entity is. Each person is encouraged to develop his or her own experience with the healing process. No AA member, group, or document attempts to define or describe what that experience will be for any given individual. There is a sharing of individual experience, strength, and hope which appears to facilitate both healing and the experience of something other than self. The description given by Ellis and Schoenfeld of some anthropomorphic Divine Being which actively intervenes to save or destroy the individual bears no resemblance to the Higher Power experienced by recovering alcoholics in AA. The most common comment is, "I learned that my Higher Power will do nothing for me that I can do for myself."

The argument proposed by Ellis and Schoenfeld is both anti-intellectual and unscientific. It is anti-intellectual in that it recognizes nothing which is not human or tangible. To equate the human experience with drugs, food, and gambling with the internal experience of a Higher Power scoffs at the history of man trying to comprehend the mysteries and possibilities of personal growth (Campbell, 1968).

Doctors Ellis and Schoenfeld reply

In his denial of the religious nature of AA, Dr. John Chappel states that "there is no creed, dogma, or theology to be learned with accompanying ceremonies for joining." We simply invite him, or others who doubt the religiosity of AA, to read the 12 Steps again, and to attend some AA meetings. We have attended many. All of them began and ended with prayers to God. Our dictionary defines theology as "the study of God and the relation between God and the universe." It is true that the only requirement for joining AA is a desire to stop drinking. But AA then bombards its members with creed, dogma, and theology in meetings and through its literature. Chappel's own words explain why we would like to remove the religio-spiritual components from 12 Step programs. He says, "We share the authors' objections to teaching religious beliefs in treatment. Many of our patients have suffered rejection and intolerance from religious organizations. It would be cruel and inhumane to repeat these experiences in treatment."

Chappel seems unable or unwilling to understand that his statement regarding "some creative force beyond our limited comprehension created the world and is present in it" is a religious belief. We do not pretend to understand the origins of the universe or its direction, if any, but feel no need whatsoever to make an "acknowledgement" to a Higher Power.

Commentary and Reply *(continued)*

From G. Douglas Talbott
Talbott Recovery System
Atlanta, Georgia

The most serious flaw in this paper is that Dr. Ellis and Dr. Schoenfeld do not distinguish between spirituality and religion in the alcoholic. The malignant denial in relation to alcoholism and other drug addictions is based upon the internal pain imposed upon the individual by his or her disease. This internal pain arises from not understanding their own compulsive behavior, from denial, and from their belief that alcoholics and other drug addicts can "cure" themselves. The spiritual aspect of Alcoholics Anonymous states that a power outside of the individual, a force greater than the individual, is necessary for the recovery. The founder and initial 100 alcoholics were extremely careful to guard against a specific religious approach, such as using the words "Divine" and emphasized in the Third Step "God as we understood Him." Yet, these authors assume the word "God" in a religious context. If one reads of the teachings of Mr. Bill Wilson in the magazine "Grapevine," specifically in the chapters relating to "God as we understood Him," the founder makes the specific point that there is no room for the word "theology" in the spiritual approach of Alcoholics Anonymous. Those knowledgeable about Alcoholics Anonymous will focus that the "Power greater than themselves" is the spirituality of the program, and not a religious or "Divine" reference. Unless alcoholics feel that they need help in recovery outside of themselves, a power, a force greater than themselves, recovery is not possible. This force is usually found in other humans in a loving relationship. The denial and recidivism of seeking chemical relief from internal pain is based on the self-delusion of being able to recover by themselves. Throughout the Alcoholics Anonymous literature, religious reference to a religious "God" is refuted, and "God" in the traditional religious sense is cautioned against as a crutch.

Doctors Ellis and Schoenfeld reply

Doctor Talbott states that "the Power greater than themselves is the spirituality of the program, and not a religious or Divine reference." Of course, many AA members do try to interpret "spirituality" in a non-religious context to avoid violating their personal religious beliefs. But we refer Doctor Talbott to the 12 Steps. Reading them can surely lead only to the sobering conclusion that they invoke a sectarian notion of the Divine.

Doctor Talbott says that "unless alcoholics feel that they need help in recovery outside of themselves, a power, a force greater than themselves, then recovery is not possible." This is obviously not so. In all probability, many more people have given up drinking on their own than through AA or any group, family, or therapist support.

From Abraham J. Twerski
Gateway Rehabilitation Center
Aliquippa, Pennsylvania

In Ellis and Schoenfeld's critique of Alcoholics Anonymous and related 12-step programs, they claim that AA, despite its disclaimers, is a program based on religious beliefs, that teaching addicted people that they can recover only by accepting a Higher Power locks them into a pattern of dependence on something outside themselves in order to function and is thus "destructive to the treatment process," and that many more people would benefit from the valuable components of the 12-step programs if the religious orientation were deleted.

If there are so many people eager to recover who are avoiding AA only because of its religious orientation, all one would need to do is announce the formation of a self-help group which insists on total abstinence but does not in-

voke God in its program. After all, for compulsive overeaters there are programs such as Weight Watchers, TOPS, and several others besides the 12-Step Overeaters Anonymous. If the authors are correct, the meeting place should be crowded with all those thousands of alcoholics who really want to abstain from alcohol but are turned off by AA's religious character. This is certainly a simple experiment which will quickly establish or refute the authors' thesis, and one which does not involve much expense. In the interest of science, this is something which should be done. In the meantime, we would be wise to follow the admittedly unscientific but highly practical adage, "If it's working good, don't fix it."

Doctors Ellis and Schoenfeld reply

Dr. Abraham Twerski states that "spirituality, which is a cornerstone of 12-step recovery, need not be of a religious character." If it isn't, why call it spirituality? Wouldn't it be far better to use terms like meaningful, significant, humanistic, intentional, attitudinal, courageous, vigorous, enthusiastic, or philosophic, rather than spiritual?

Twerski says that if we are correct, the meeting places of non-AA groups "should be crowded with all those thousands of alcoholics who really want to abstain from alcohol but are turned off by AA's religious character." This is actually beginning to happen. Thousands of individuals are now joining the secular support groups we have mentioned.

We suggest controlled studies to demonstrate whether recovery from addictions is helped, harmed, or unaffected by the religious-spiritual elements of Alcoholics Anonymous and related 12 Step programs. Let Skinner's humanistic 12 steps and support groups using rational-emotive therapy (RET) and cognitive-behavior therapy (CBT) be empirically tested against the 12 Steps of AA. Is it not time to free substance abuse treatment from the thrall of medieval superstition? The field of Addiction Medicine is struggling for recognition as a bona fide medical specialty. This objective is poorly served by its ties with sectarian religious beliefs. □

We suggest controlled studies to demonstrate whether recovery from addictions is helped, harmed, or unaffected by the religious-spiritual elements of Alcoholics Anonymous and related 12 Step programs.

The Tenth Tradition*

Garrett O'Connor, MD

To propose, as Ellis and Schoenfeld[1] have done, that AA should abandon its spiritual stance in favor of joining the psychiatric mainstream is like asking Moslems to give up Mohammed. It simply won't happen, and to insist that it should is at best pointless and at worst frivolous.

At the workshop entitled Spirituality and its Place in the Practice of Addiction Medicine, held in November at our annual meeting, I pointed out that psychiatrists and addictionists have in common the fact that many of their patients are completely demoralized. (I also noted that I had been the creator and director of the 1985 CSAM conference titled Conflict and Cooperation Between Psychotherapy and the Twelve Step Approach which Ellis and Schoenfeld criticized in their 1990 article.)

The dictionary definition of demoralization is "to be deprived of spirit, courage and hope; to be bewildered, disheartened, confused, despairing, alienated and disordered." AA was designed by and for alcoholics who have reached a state of "incomprehensible demoralization."[2] No words can describe the malignant emotions that engulf the alcoholic as he or she approaches the terminal stages of the disease. Those of us who have experienced and survived this appalling descent will recall that while many of us remained outwardly respectable, our inner experience was one of shame, regret, fraudulence, guilt, hypocrisy, fear, terror and despair. For the most part, "rational" therapies had failed to impact our consciousness or behavior. Many of us were veterans of multiple therapeutic approaches including religion and psychotherapy in all its forms: psychoanalytic, psychopharmacological, rational emotive, eclectic, behavioral, cognitive, and supportive.

Our situation was somewhat similar to the relationship between quantum theory and mundane physics as described by Stephen Hawking. At the boundary of a singularity or a black hole, the rational laws of science no longer apply. The same is true for an alcoholic about to hit bottom. The rational rules of psychology break down because the individual, like matter at the edge of a black hole, has entered a different dimension of reality. A person experiencing "incomprehensible demoralization" is alienated and dispirited to the point of being less than fully human and is therefore totally inaccessible by *ordinary* means of communication. Something bigger, stronger, more overwhelming is needed to make contact with the devastated self behind the alcoholic facade.

It is precisely this awesome, non-rational dimension which 12 Step people call spiritual and many others identify as religious that has attracted millions of dying alcoholics for whom "rational" approaches have failed. This was certainly true in my case. I had managed over a period of 20 years to defeat all efforts to help me to stop drinking. These included religion, two psychoanalyses, ferocious applications of willpower, and the periodic mobilization of squadrons of concerned persons including relatives, friends, colleagues, and two wives – all of whom had failed in their best-intentioned efforts to reach me with a message based on standard family and societal values. Had it not been for an approach that provided me with an expectation of hope through spirituality, I am convinced I would be dead. If Ellis and Schoenfeld insist that my survival is due to an experience of religious conversion, then so be it. I don't agree. It has been said, and my personal experience bears it out, that religion is for people who are trying to avoid hell,

It is precisely this awesome, non-rational dimension which 12 Step people call spiritual and others identify as religious that has attracted millions of dying alcoholics for whom "rational" approaches have failed.

while spirituality is for those who have already been there.

I am sure that neither Schoenfeld nor Ellis is conscious of the fact that their proposals reflect the attitudes of an increasingly large segment of society which favors the abandonment or even elimination of population groups who fail to meet mainstream criteria. Gays, the homeless, the seriously mentally ill, and Moslems in Bośnia are current examples of such groups that come to mind. On the MacNeil Lehrer televison news program of Novem-

*The Tenth Tradition: Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

ber 18, 1992, a prominent expert on international affairs advocated a laissez-faire approach to the crisis in Somalia because for economic, political and ethnographic reasons the common people of that country were "probably not a viable population" and should, therefore, be allowed to die out.

If the Ellis/Schoenfeld proposal to remove the spiritual component of AA were implemented, what would happen to the millions of dying alcoholics who have found physical and spiritual recovery in AA and for whom "rational" approaches had failed abysmally? Skinner's Humanist 12 Steps suggested by Ellis and Schoenfeld as a substitute for AA's spiritual program are eminently rational and highly reasonable. However, they would not have worked for me in 1977 when I was at the end stage of my disease. As I did with all the other well-meaning "scientific" methods for helping alcoholics to stop drinking, I would have found some way to subvert their purpose and to continue alone and unchecked along the downward path of my own destruction.

Although it may seem harsh to say it, the Ellis/Schoenfeld proposal is, in fact, an inadvertent form of death sentence for seriously ill alcoholics. In truth, it is a well-intentioned proposal with distinctly genocidal implications for the very class of people it intends to help.

It is a commonplace in history that human behavior is often at its best when human conditions are at their worst. The great famine in nineteenth century Ireland, the Jewish holocaust in Hitler's Germany, and more recently, the current epidemic of AIDS have all produced examples of ennobling heroism by ordinary people who found somewhere within themselves the spiritual qualities of transcendence which enabled them to choose survival over abandonment or annihilation.

The program suggested by Ellis and Schoenfeld to replace AA emphasizes individual autonomy over mutual interdependence. For this reason it will undoubtedly attract alcoholics who are unwilling or unable to accommodate to the spiritual approach of AA. Whether or not this substitute program will prove to be of value in the long term remains to be seen.

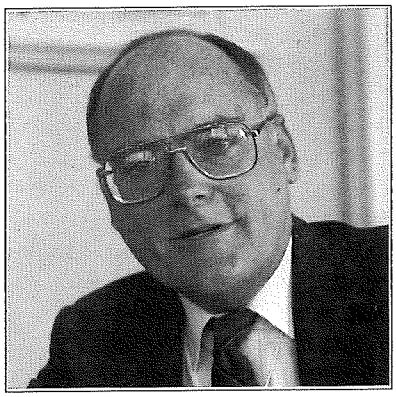
In the meantime I would encourage Ellis and Schoenfeld to abandon their efforts to change AA and instead devote their energies to developing the alternative program they espouse. Suffering alcoholics are quite literally a dying breed and need all the help they can get, from whatever source. AA makes no claim to a monopoly on recovery. □

References

1. Ellis, A and Schoenfeld, E. Divine Intervention and the Treatment of Chemical Dependency. **Journal of Substance Abuse**, 1990, 2:459-468.

2. Alcoholics Anonymous. **The Big Book (3rd edition)**. New York: Alcoholics Anonymous World Services, Inc., 1976.

California Society 19th Annual Meeting



President's Column

New Members on the Executive Council

During the Review Course and Annual Meeting in Long Beach from November 5 to 7, elections were held during the business meeting of the members. Karen Sees, DO, and Nicola Longmuir, MD, were each elected to two-year terms as members-at-large on the Executive Council. Peter Banys, MD, and Margaret Gregory, MD, went out of office, having served the maximum time allowable under our bylaws: two 2-year terms. Doctor Longmuir, a member since 1985, is a Board-certified internist working with Kaiser in Oakland. She served on the planning group for the Review Course in 1990. Both she and Doctor Sees completed the two-year fellowship in substance abuse at the San Francisco VA: Longmuir in 1984-86 and Sees in 1987-89. Doctor Sees, an internist, is Assistant Chief of the Substance Abuse Treatment Clinic at the SF VA. In November, she was elected President of the American Osteopathic Academy of Addictionology. She also serves on several committees of ASAM; among them are the Examination Committee, the Nicotine Dependence Committee, and the Methadone Committee. We look forward to the viewpoints and experience they will bring to our deliberations. □

Community Service Award

William Brostoff, MD, presented the Award with this introduction, which included comments from David Smith, MD:

For over 25 years, the Haight-Ashbury Free Medical Clinics have operated under the philosophy that medical care is a right, not a privilege. This is the guiding principle which keeps the Clinics focused on humane, non-judgmental, demystified health care. Darryl Inaba has always personified this philosophy from the very beginning of his association with the Clinic in 1967 as a student pharmacist. He became the Director of Pharmaceutical Services in 1971, and now is the head of the Haight-Ashbury Free Clinics' Drug Treatment Program, a position he has held since 1978. His commitment and vision have provided the leadership to keep the Clinics on a steady course.

Throughout the years he has pursued a major interest in health care in the Asian American community; he is the founder of the now national Asian and Pacific Islanders Families Against Substance Abuse.

He is perhaps best known to many of us as a charismatic and dynamic teacher and lecturer, committed to providing accurate, up-to-date information about drugs and drug use.

CSAM

The California Society of Addiction Medicine
presents the

Community Service Award

to

Darryl Inaba, PharmD

in recognition of his contributions to the education of the many physicians and health care professionals who have come to the Haight-Ashbury Free Medical Clinics for training over the last 25 years,

his dedication to the highest standards of compassionate treatment for those suffering from drug dependencies and alcoholism, and

his untiring advocacy for the health of the whole community.

ANNUAL MEETING November 1992 LONG BEACH

Vernelle Fox Award

Richard Sandor, MD, David Smith, MD, and Jokichi Takamine, MD, each contributed introductory comments:

Tom occupies a very special role – that of a statesman whose vision has set a course and helped keep us on the course. His role on the National Commission on Marijuana in the 1970s was historic in getting a nomen-

clature system and a description of the levels of addiction that set the stage for the development of our field. We have all benefitted from his continuing advocacy for research.

His role as teacher is being highlighted now because of the Interactive Teaching seminar in Substance Abuse which he developed at UCLA. Anybody who teaches knows that the really great awards come from your students. Here is what students have said: "I think everybody – medical students, doctors, and normal people – should take this course." "I became too emotional during my debate and 12 Step visit, but I learned so much." "It is the single best class this semester for my overall practice of the future."

CSAM

The California Society of Addiction Medicine
presents the

Vernelle Fox Award

to

J. Thomas Ungerleider, MD

in recognition of his outstanding contributions
to the field of addiction medicine
in the areas of public and medical education.

His efforts to bring practical instruction to children
in our public schools through the DARE program
have been a model for the whole nation.

Similarly, his success in developing innovative and exciting
substance abuse education programs for medical students
at UCLA deserves our recognition and commendation.

Doctor Ungerleider with others associated with his award-winning Interactive Teaching Course at UCLA. From the left: Robert Coombs, PhD; Jokichi Takamine, MD; Cassandra Franker; Alice Wallbon who was a medical student in the course; Milton Birnbaum, MD.

ANNUAL MEETING November 1992 LONG BEACH

Buprenorphine Treatment of Opiate Dependency

Walter Ling, MD, and Donald R. Wesson, MD

Buprenorphine has a pharmacological profile that suggests usefulness for opiate detoxification and opiate maintenance (Jasinski, Pevnick and Griffith, 1978). For some opiate addicts, it may have significant advantages over methadone.

The effects of buprenorphine at the mu receptor are complex. At low dosages, the effects are predominantly those of an opiate agonist. As the dose is increased, opiate antagonist effects become increasingly dominant. Consequently, buprenorphine is less likely than methadone to produce life-threatening respiratory depression if taken in an overdose. Although heroin addicts do self-administer buprenorphine, its abuse potential appears to be less than methadone's. Buprenorphine also appears to produce a lower level of physical dependence than methadone. This may make it easier for patients on buprenorphine to stop maintenance treatment eventually and remain opiate-free. These characteristics may make the drug ideal for earlier intervention with patients whose history of opiate dependence is of shorter duration and for whom the course of treatment may be expected to be shorter than with methadone maintenance.

As the dose is increased, opiate antagonist effects become increasingly dominant.

Buprenorphine is available in the US only as an injectable product, Buprenex®, for treatment of pain. The usual injectable dose of Buprenex®, in a non-opiate tolerant patient, is 0.3 mg every six hours. Buprenorphine is available in analgesic doses as a sublingual tablet in Europe, Australia and New Zealand. The sublingual doses used in clinical studies in the US for treatment of opiate dependence are considerably larger than those used for treatment of pain.

NIDA Seeks New Therapeutic Indication for Buprenorphine

NIDA's Medication Development Division is sponsoring studies to support a New Drug Application (NDA) that proposes to add treatment of opiate dependence to the approved therapeutic indications for buprenorphine. Three clinical trials are expected to provide "pivotal" data for establishing the efficacy and safety of buprenorphine. (Pivotal studies are those that are weighted most heavily by FDA in considering efficacy. Such studies must be conducted under rigorous FDA guidelines, which require detailed documentation as well as availability of all source documents.) The three are the ARC Study, recently published; the LAATRU Study and a Multicenter Study, both currently in progress.

These characteristics may make the drug ideal for earlier intervention with patients whose history of opiate dependence is of shorter duration and for whom the course of treatment may be expected to be shorter than with methadone maintenance.

The main findings of the study conducted at NIDA's Addiction Research Center (ARC) in Baltimore and completed in 1990 were recently published in *JAMA* (Johnson, Jaffe, Fudala, 1992). The study compared eight mg of buprenorphine to 20 and 60 mg of methadone. Eight milligrams of buprenorphine was significantly better than 20 mg of methadone in retaining subjects, and reducing opiate use: the percentage of urine samples negative for opiates was significantly greater with buprenorphine (53%) than with 20 mg of methadone (29%).

As previously reported in *NEWS* (Fall, 1990), a randomized, double-blind clinical trial comparing eight mg of buprenorphine to 30 and 80 mg of methadone as a maintenance medication is being conducted at Pizarro Treatment Center in Los Angeles as a project of the Los Angeles Addiction Treatment Research Unit (LAATRU). It involves 225 subjects treated with buprenorphine or methadone for up to one year. (Some subjects are being allowed to continue on buprenorphine beyond a year for the purpose of gathering long-term safety information.) Subject enrollment was completed in mid-October.

On April 15, 1992, the first subject was enrolled in the Multicenter Study – a 16-week, randomized clinical trial comparing four doses of buprenorphine: 1, 4, 8, and 16 mg. The study will involve up to 720 subjects at 12 sites, four of which are in California: Pizarro Treatment Center and West Los Angeles Treat-

ment Program in Los Angeles, and San Francisco General Hospital and San Francisco VA Hospital. To date, over 500 subjects have been enrolled in the study.

The Los Angeles Treatment Research Center, the Clinical Coordinating Center, publishes a newsletter which updates sites on progress of the study and discusses other issues related to buprenorphine. A copy of the newsletter may be obtained by writing Sandy Dow, 8447 Wilshire Blvd., Suite 409, Beverly Hills, CA 90211.

As additional findings from these studies are reported, we will describe them for *NEWS*. □

References

Jasinski, DR, Pevnick, JS, Griffith, JD. "Human pharmacology and abuse potential of the analgesic buprenorphine." **Arch Gen Psychiatry**, 1978; 35: 501-516.

Johnson, RE, Jaffe, JH, Fudala, PJ. "A controlled trial of buprenorphine treatment of opioid dependence." **JAMA** 1992; 267(20): 2750-2755.

You Can Write For

NIDA Research Monograph, *Buprenorphine: An Alternative Treatment for Opioid Dependence*, is now available from the National Clearinghouse for Alcohol and Drug Information (NCADI). Edited by Jack D. Blaine, MD, of NIDA, the monograph is based on papers and discussions from a NIDA-sponsored technical review held in 1989. Single copies are free from NCADI, P. O. Box 2345, Rockville, MD 20852; telephone 800/729-6686. Additional copies may be purchased for $3 each from the Government Printing Office. Refer to DHHS publication number (ADM)92-1912. □

ACKNOWLEDGMENT

The California Society gratefully acknowledges a contribution received from The Upjohn Company in support of the Society's educational programs.

California's Diversion Program for Physicians

The Medical Board of California's Diversion Program will enter its 13th year in January. Since it began on January 1, 1980, the program has successfully "graduated" 383 physicians. Two hundred forty-two are currently enrolled, and 29 are awaiting acceptance into the program. Applicants for Diversion must be accepted by a Diversion Evaluation Committee and must sign an individualized treatment agreement. Fewer than half of the current participants were referred to the Program by the disciplinary arm of the Medical Board; 132 were referred through other channels.

DECs

Composition of the Diversion Evaluation Committees (DECs) is regulated: of the five members, three must be physicians (one a psychiatrist) and two must be non-physicians. All must be knowledgeable about alcoholism and other drug dependence. The term of appointment is six years. Currently there are three vacancies on the rosters of the DECs. Appointments are made by the Division of Medical Quality of the Medical Board.

Northern I
Kevin Olden, MD, Chair
Michael Smith, MD
William Brostoff, MD
Marsha Young, PhD
One Vacancy for a non-physician
Sharon Ryerse, MFCC

Northern II
Barbara Burdan, MD, Chair
Lyman Boynton, MD
One Vacancy for a physician
Robert Matano, PhD
Jeff Roth

Southern I
Margaret Yates, MD, Chair
Harvey Lerner, MD
Robert Tarter, MD
Howard Pack
Linda Oliver

Southern II
David Murphy, MD
Joel Berman, MD
H. Westley Clark, MD, JD, MPH
Judge J. William Beard
Marilyn Sponza

Southern III
Gail Schultz, MD, Chair
Donald Gragg, MD
Donald Dougherty, MD
Keven Bellows
Emmanuel Gomez

The Sixth DEC
Margaret Gregory, MD
Norman Reynolds, MD
One Vacancy for a physician
Cassandra de la Coeur, PhD
Steven Clark, PhD

For more information, contact the Program Manager, Chet Pelton, 2135 Butano Drive, Suite 92, Sacramento, CA 95825; 916/924-2561. □

Identifying Alcohol-related Problems

A Clinician's View of Screening Instruments

William S. Brostoff, MD

Editors' note: Doctor Brostoff gave the lecture on assessment and diagnosis at the 1992 Review Course. This article is taken from his lecture.

Depending on the setting and the circumstances in which we see patients, and on the definition we use, the incidence of alcoholism can vary considerably: 5% to 10% in the general population, up to 20% or more in medical clinics, even up to 50% in hospitals, as shown in some studies. How do we identify these patients? How do we diagnose them?

It is the *accumulation* of alcohol-related problems that helps us make the diagnosis of alcoholism. The study which George Vaillant describes at length in *The Natural History of Alcoholism* has clearly demonstrated that the more alcohol-related problems an individual has the more likely that the condition is alcoholism. By the way, I strongly recommend this book to you. I think it's essential for understanding what alcoholism is and what it isn't. Vaillant documents that if the patient says that he or she is alcoholic, if the patient says he or she has lost control of drinking, or if the doctor makes the diagnosis, it is alcoholism, virtually 100% of the time.

History and Physical Exam

As physicians, we identify alcohol-related problems the same way we recognize patterns in other conditions in medicine. We take a good history, do a thorough physical examination, get the appropriate lab tests, and evaluate all the information together. As we are taking the history, we pay particular attention to certain parts of it and to conditions which we know are associated with alcoholism. Ulcers, hypertension and gout, for example, don't diagnose alcoholism, but they can alert us to ask more specifically about the person's drinking. Likewise, a family history of alcohol or other drug problems is going to focus us more sharply. Depending upon the information and answers we get initially, we target the history and shape our questions accordingly.

More than anything, it's the quality of the answer that alerts me. I'm listening very closely for what the person's voice sounds like. I'm listening for the emotional component of the answer. I'm listening for hesitations and qualified answers. I take note of small subtleties.

Denial is a part of the disease, as we know not only from the definition of alcoholism, but also from our clinical experience. Getting a reliable history of alcohol and other drug use is an essential but, because of the way denial operates in alcoholics and sometimes in their family members, it requires experience, skill, subtlety and tact. At the least, it requires being as down to earth and straight forward and supportive as we can as physicians. As we accept more and more that alcoholism and drug depen-

Table 1: BMAST

1. Do you feel you are a normal drinker?	6. Have you ever neglected your obligations, your family, or work for two or more days in a row because you were drinking?
2. Do friends or relatives think you are a normal drinker?	7. Have you ever had delirium tremens (DTs), severe shaking, or seen things that weren't there after heavy drinking?
3. Have you ever attended a meeting of Alcoholics Anonymous (AA)?	8. Have you ever gone to anyone for help about your drinking?
4. Have you ever lost friends or girlfriends/boyfriends because of drinking?	9. Have you ever been in a hospital because of drinking?
5. Have you ever gotten into trouble at work because of drinking?	10. Have you ever been arrested for drunk driving or driving after drinking?

(Pokorny et al, 1972)

Table 2: CAGE

Questions
Have you ever felt the need to Cut down on your drinking?
Have you ever felt Annoyed by criticism of your drinking?
Have you ever felt Guilty about your drinking?
Have you ever taken a morning Eye opener?

Number of positive answers	Sensitivity %	Specificity %
all 4 items	37	100
3 items	67	98
2 items	81	89
1 item	90	21

(Mayfield et al, 1974)

dence are important diseases that must be ruled out like other diseases, this interchange with the patient will become more routine. In the meantime, I believe we can all use some tips:

- Be friendly but persistent
- Be matter of fact
- Express support
- Recognize qualified answers
- Watch affect and emotion
- Be suspicious of "No problem"
- Listen for rationalizations

Information from other sources is also very important. If a relative calls and says, "So-and-so is going to see you today and she has a terrible drinking problem," you may not be able to use that information directly in the clinical setting, but it certainly is something that will alert you and make you rule out the diagnosis of alcoholism.

The physical exam is certainly important. It's not often diagnostic of alcoholism in its early phases, but I think you have to pay close attention to signs of use or abuse, signs of withdrawal, and, obviously, signs of drug- or alcohol-related disease.

Screening instruments

The MAST, the CAGE, the FOY, the two-question screen and the Trauma Scale look for self-perceived loss of control, loss of control as perceived by others, continued drinking despite adverse consequences, evidence of tolerance and withdrawal.

One of the first instruments to be developed and one of the most widely used is the MAST, the 25-item Michigan Alcoholism Screening Test (Selzer, 1971). For me, it is not a good instrument for use in the office setting because it takes too long. The short MAST, or SMAST, uses 13 questions from the MAST (Selzer, 1975). The BMAST, or Brief MAST (Table 1), pares it down to ten (Pokorny, 1972). These questions were selected because even by themselves they yield a "score" which can point to the presence of alcoholism with a high degree of sensitivity and specificity. (Sensitivity refers to the accuracy of a positive response in identifying persons with alcoholism. Specificity refers to the ability of a negative response to rule out alcoholism.) The shorter versions are virtually as effective as the full MAST. The scoring system for the MAST assigns a number of points to each answer; for example, answering "yes" to "Have you ever gone to anyone for help about your drinking?" means 5 points. Answering "no" to "Do you feel you are a normal drinker?" means 2 points. A score of 6 would indicate possible alcoholism, according to the work of Pokorny with the BMAST.

The CAGE uses only four questions from the MAST. The more positive responses, the more likely it is that I am dealing with alcoholism. You can also look to the CAGE to help rule out alcoholism, because 2 or more negative answers are highly specific. (Table 2)

"FOY" (Table 3) uses three questions. If you answer yes to even one of those questions, I am very suspicious that

Table 3: "FOY"

Has your Family ever objected to your drinking?
Have Others ever said you drank too much for your own good?
Did You ever think you drink too much in general?

(Woodruff et al., 1976)

A Clinician's View *(continued)*

I am dealing with alcoholism. The CAGE and FOY are both very useful office tools.

The two questions in Table 4, "Have you ever had a drinking problem?" and "Did you take a drink within the last 24 hours?" when used together, have shown a 92% sensitivity in identifying alcoholics. It is particularly interesting to note that the data in the table show that 91% of non-alcoholics will not have taken a drink within 24 hours of a medical examination.

Table 4: Two Question Screen

Item	Sensitivity %	Specificity %
Have you ever had a drinking problem?	70	99
Did you take a drink in the last 24 hours?	36	91
History of drinking problem and/or last drink within 24 hours	92	90

(Cyr and Wartman, 1988)

On the other hand, asking "Do you drink daily?" or "Do you drink four or more drinks a day?" is not helpful, since these questions turn out to have very low sensitivities: 34% and 47% (Cyr and Wartman, 1988). They have high specificity, but not sensitivity, so they don't help me identify alcoholism. (Table 5)

Table 5

Item	Sensitivity %	Specificity %
Do you drink daily?	34	94
Do you drink 4 or more drinks per day?	47	96

(Cyr and Wartman, 1988)

The Trauma Scale, developed by Skinner (Table 6), has fairly high sensitivity and specificity when 2 or more positive answers are considered indicative of possible alcoholism. In taking a history, if a patient says, yes, he has been injured in an assault or fight, I want to know a whole lot more about the circumstances.

Table 6: Trauma Scale

Question	Sensitivity %	Specificity %
Have you had fractures or dislocations?	88	59
Have you been injured in a motor vehicle accident?	59	74
Have you injured your head?	85	76
Have you been injured in an assault or fight?	69	91
Have you been injured after drinking?	88	93

(Skinner et al., 1984)

High risk patients

I want to emphasize that the answers to screening questions don't make the diagnosis. When screening tests or other information raise a question about alcohol or drug use, we need to take a more detailed and focused history and make a comprehensive evaluation of the history, physical exam and lab results, looking for an accumulation of problems related to alcohol and other drug use. Those who have a previous history or a family history of alcohol or drug problems and chronic pain patients who are at high risk for prescription drug dependence fall into my definition of high risk groups, and they receive the same detailed and focused history and comprehensive evaluation as those who give positive answers to the screening questions.

Summary

All patients should be asked about alcohol and drug use. If the initial responses raise questions, or if something about the answers doesn't ring true, I go back and take the history again, review it more carefully with the physical findings and the lab findings. Conversely, the history and physical exam and lab can provide clues that may lead me to administer another of the screening tests.

The different screening instruments are very helpful, but they do not replace a reliable history of alcohol and other drug use. I believe, with the editors of *Lancet*, that

"in everyday practice there remains no substitute for the alert doctor with a high degree of suspicion and yet sufficient tact to be able to take a good drinking history without alienating the patient." □

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News about Members

Richard Sandor has left the Sepulveda VA after three years and is now the Medical Director of the Chemical Dependency Center at Saint John's Hospital in Santa Monica. He continues in private practice of psychiatry in Marina del Rey.

Joe Chudy has joined Kaiser Permanente in Fresno to head their alcohol and drug abuse program, STEP: Substance Abuse Treatment and Education Program.

Gary Levine has joined an office pediatrics practice in San Francisco. He continues his practice of Adolescent Medicine in Marin County.

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.

Stephen Bochner, MD, is an obstetrician/gynecologist in private practice in Portola Valley and is on the clinical faculty at Stanford University. He graduated from Ottawa University in 1983 and completed a residency at Stanford in 1988.

Sally J. Rubenstone, MD, is a board-certified internist in private practice in San Carlos. She is medical consultant at Belmont Hills Psychiatric Hospital and an admitting physician at the Alcohol and Drug Recovery Unit at Sequoia Hospital. She graduated from Stanford University in 1983 and completed a residency at Kaiser Hospital in Santa Clara in 1987.

Other applicants include:
J. Thomas Payte, MD, Texas

In Memoriam

Robert "Pete" Peterson, MD, of Fresno, died in the spring of this year from complications of pulmonary disease. He had been a member since 1984 and had served most recently on the Society's Committee on Treatment Outcome where he made significant contributions to the development of the "Recommendations for Design of Treatment Efficacy Research." □

CONTINUING MEDICAL EDUCATION

ASAM's 3rd Patient Placement Criteria Conference

JW Marriott Hotel at Lenox, Atlanta, Georgia
Feburary 19-21, 1993
Fees: $350 for ASAM members; $400 for non-members until February 1
Credit: 15 hours
Speakers include David Bravlove, Esq.; Christine Kasser, MD; David Mee-Lee, MD; Michael Miller, MD
For information, contact ASAM, 5225 Wisconsin Avenue, NW, Washington, DC 20015; 202/244-8948.

13th Annual Betty Ford Center Conference

Annenberg Center for Health Sciences at Eisenhower Medical Center, Rancho Mirage
February 22-24, 1993
For information, contact Karen Thomas, 800/321-3690.

Part of CMA Annual Western Scientific Assembly

Algorithms for Alcoholics

Sponsored by the California Medical Association Section on Psychiatry and CSAM
Disneyland Hotel
Sunday, February 28, 1993
Fees: For CMA members, no fee
Credit: 3 hours
Speakers include Garrett O'Connor, MD, Kevin Olden, MD, Gary Eaton, MD, Donald Gragg, MD
For information, contact California Medical Association, 415/882-3384.

ASAM's 24th Annual Medical-Scientific Conference

Bonaventure Hotel, Los Angeles
April 29 - May 2, 1993
Topics for the symposia (no fee sessions) include Research for Motivation for Treatment, Brief Interventions for Alcohol Use Problems, Bio-Behavioral Correlates of Relapse, Benzodiazepine Dependence, Perinatal Addiction, Needle Supply and Other Harm Reduction Strategies, Adolescents and Smoking
For information contact ASAM, 5225 Wisconsin Avenue NW, Washington, DC 20015-2016; 202/244-8948.

26th Anniversary Conference

The Chemically Dependent Physician and Prescription Drug Issues

Sponsored by Haight Ashbury Free Clinics
June 4-5, 1993
Speakers include G. Douglas Talbott, MD; Chet Pelton; Donald R. Wesson, MD; Walter Ling, MD
For information, call Haight Ashbury Training, 415/565-1902.

College on Problems of Drug Dependence (CPDD) 55th Annual Scientific Meeting

Toronto
June 12 - 17, 1993
Fees: $175 for members of CPDD; $215 for non-members. After April 15, add $50.
For information, contact Martin W. Adler, PhD, Department of Pharmacology, Temple University School of Medicine, 3420 N. Broad Street, Philadelphia, PA 19140.

Research Society on Alcoholism 1993 Annual Meeting

San Antonio
June 19 - 24, 1993
For information, contact Debra Sharp, 4314 Medical Parkway, Suite 300, Austin, TX 78756; 512/454-0022.
