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NALTREXONE TREATMENT OF ALCOHOL DEPENDENCE

Donald R. Wesson, MD, David E. Smith, MD, Walter Ling, MD

Last November, widespread public interest in naltrexone as a treatment for alcohol dependence was stimulated by newspaper articles based on an Associated Press release with the headline, "Drug Appears to Prevent Relapse of Alcoholism." The articles and subsequent television coverage described two studies in the *Archives of General Psychiatry*.

Reports from both studies had appeared before. Preliminary findings of the Philadelphia study were reported in a book chapter (Volpicelli, O'Brien and Alterman 1990). A July 8th, 1991, newspaper article in the *Wall Street Journal* had reported that naltrexone was being studied for treatment of alcohol dependence (Stipp 1991). Results from the Yale study had been previously reported in two conferences of the Research Society on Alcoholism and abstracts of both had been published (O'Malley 1991; O'Malley 1990).

The first study was conducted by Joseph Volpicelli. Seventy newly admitted alcohol dependent men receiving outpatient rehabilitation treatment at the Substance Abuse Treatment Unit of the Philadelphia Veterans Affairs Medical Center were subjects in the study. For the first week, all subjects received placebo. They were then randomly assigned to receive either naltrexone 50 mg/day or identical-appearing placebo tablets. Subjects self-administered their medication for 12 weeks. The men treated with naltrexone reported significantly less craving for alcohol and significantly fewer relapses. (The investigators defined relapse as reporting drinking on 5 or more days within 1 week, reporting 5 or more drinks per drinking occasion, or coming to the treatment appointment with a blood alcohol concentration above 100 mg/dl.) Twenty-three percent of the naltrexone subjects relapsed compared to 54 percent of the placebo treated subjects (Volpicelli et al. 1992).

In the second study, conducted at the outpatient Alcohol Treatment Unit of the Connecticut Mental Health Center in New Haven, 97 subjects who met DSM-III-R criteria for alcohol dependence and who had at least 7 days of abstinence were randomly assigned to either naltrexone 50 mg/day or placebo. Subjects in this double-blind study were given the doses for 12 weeks

Naltrexone Treatment (continued)

and were randomly assigned to either coping skill therapy or supportive therapy. Relapse was defined for men as drinking five or more drinks on an occasion and for women as drinking four or more drinks. Almost all the subjects on placebo in both the skill training and supportive therapy relapsed compared to 34 percent of the subjects in the naltrexone/support therapy group and 43 percent in the naltrexone/coping skills group (O'Malley et al. 1992).

Neurochemical Studies

There is a growing body of neurochemical, animal, and now human studies suggesting that opiate receptors, opiate neurotransmitters or both are involved in regulation of alcohol intake (Cushman 1987; George et al. 1991).

In 1970, Cohen and Collins reported the biosynthesis of tetraisoquinoline (TIQ) alkaloids from catecholamines and acetaldehyde. They perfused cow adrenal glands with dilute solutions of acetaldehyde and found that condensation reactions occurred with epinephrine, norepinephrine, or dopamine. The reaction, shown in Fig-

ure 1 for dopamine, forms 1-methyl-6,7 dihydroxy-isoquinoline, more commonly known as salsolinol. TIQs are chemically related to plant alkaloids that have opioid-like effects. The finding that tetraisoquinolines were produced in animals provided a plausible neurochemical link between alcohol use and opioid effects.

If some alcohol users produce larger quantities of salsolinol, it could explain why they have a qualitatively different response to alcohol. The blockade of salsolinol's opiate effect at the *mu*-opiate receptor would also explain why an opiate blocker, such as naltrexone, could be a useful therapeutic intervention in treatment of alcohol abuse, particularly for patients who continued to drink. The biochemical or receptor effects are apparently not confined to alcoholics. Naloxone and naltrexone have been found to reduce alcohol consumption in rats (Hubbell et al. 1986) and in macaque monkeys (Myers et al. 1986).

Discussion

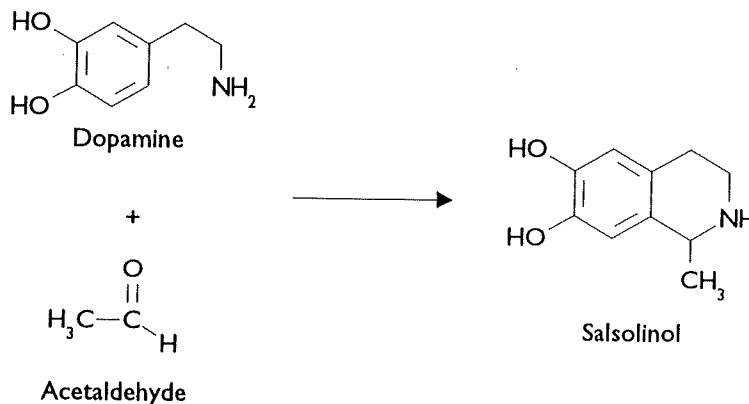
If naltrexone works as suggested, its primary usefulness will be in treat-

ment of patients who continue to imbibe. Unless patients consume alcohol, naltrexone would not be expected to have a pharmacological effect. Then the reinforcing effects of alcohol—at least the value-added effect of salsolinol—would be attenuated.

The popular press focused on reduction of craving for alcohol as an effect of naltrexone. It is important to emphasize, however, that the studies did not present evidence that alcohol craving was reduced among subjects who didn't drink. Craving was less among subjects treated with naltrexone, and so was their use of alcohol. It doesn't necessarily follow that subjects didn't drink more because their craving was less. Alcohol use itself begets craving for alcohol. Increased craving among placebo subjects could be because, as a group, they drank more.

This chicken and egg conundrum is of considerable practical and theoretical importance. If naltrexone reduces alcohol craving in non-drinking alcoholics in early recovery, then the pharmacological mechanism is different than currently proposed.

Figure 1. The formation of salsolinol from dopamine and acetaldehyde. The reaction for norepinephrine and epinephrine is similar. Norepinephrine produces 1-methyl-4,6,7 trihydroxy-1,2,3,4-tetrahydroisoquinoline; epinephrine produces 1,2 dimethyl-4,6,7 trihydroxy-1,2,3,4-tetrahydroisoquinoline.



Naltrexone shows considerable promise as a treatment adjunct among patients who continue to use alcohol where the goal is to reduce, rather than completely stop, alcohol consumption. Its role as an adjunct to drug-free, recovery-oriented, abstinence treatment is unknown and needs further exploration.

Recent shifts in public policy have given medication development in treatment of alcohol and drug

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abuse increasing priority. NIDA and NIAAA encourage involvement of individual investigators and pharmaceutical companies in such studies. FDA has established a committee to develop guidelines for reviewing studies of medications used for treatment of alcohol and other drug abuse and made their review a priority. NIAAA has intensified its medication development efforts and is specifically encouraging investigators to conduct trials of medications for treatment of alcohol dependence. It has already funded a new round of clinical trials of naltrexone in treatment of alcoholism, including new studies by the groups at Philadelphia and Yale. As additional findings from the studies are reported, we will review them in NEWS. □

942 words

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"Children of Alcoholics" Labels a Population, Not a Disease

Timmen L. Cermak, MD

Editors' Note: Ten years ago, the newsletter carried an article by Doctor Cermak on this subject as the concepts were first brought to the attention of physicians and other therapists.

See Children of Alcoholics, Vol. 10, No. 4, December 1983, California Society for the Treatment of Alcoholism and Other Drug Dependency NEWS.

This article first appeared in The Psychiatric Times in December, 1992. Permission to use the article has been received.

Medicine traditionally defines a disease first, and then looks for the population which suffers from that disease. In the case of young and adult children of alcoholics (COA), this process has been reversed. A population has been identified first (in large part because of the drive by adult COAs for recognition). We must now ask whether this population has any clinical significance.

Such a reversal of the traditional process is not without precedent. The feminist movement identified women as a population with its own legitimate perspectives, experience and concerns. Many psychiatrists now accept that familiarity with the feminist perspective facilitates respect for women's experience that can increase the effectiveness of treatment. The same is true for understanding and respecting the perspective of COAs.

There are, of course, more than sufficient reasons to dismiss the entire recent focus on COAs as faddish, opportunistic and without psychological sophistication. "COA issues" have become a fad for many people—the latest "answer" to what is wrong with them. They have

also provided some charismatic leaders an opportunity for profit and fame. However, the actions of a few should be irrelevant to an academic exploration of the phenomena before us.

The offspring of substance abusing parents constitute a legitimate population to study, for no other reason than their huge numbers. An estimated 28,000,000 Americans have at least one parent who is alco-

"COA issues" have become a fad,...but that should be irrelevant to an academic exploration of the phenomena before us.

holic.¹ Over 6,000,000 of these are under the age of 18 years old.² Since alcoholism represents approximately two thirds of the substance abuse in the US, the total number of Americans under 18 years old with a substance abusing parent is probably 9-10,000,000.³

Such impressive numbers constitute a mammoth "experiment of nature," allowing us to explore the effects on normal child development of a wide range of phenomena, including (but not limited to) prenatal exposure to psychoactive substances, direct genetic inheritances, parental loss (through divorce and early death), overt physical and sexual abuse, neglect, arbitrary fluctuations in parental personality and emotional unavailability, and the imprint on children of the narcissism that generally develops in substance abusers.

A modification of Theodore Millon's⁴ framework for under-

standing the origin of personality disorders effectively organizes the robust array of sequelae occurring in COAs. As I outlined in *Evaluating and Treating Adult Children of Alcoholics*, a full psychological evaluation of patients with chemically dependent parents requires gathering data in at least four different areas: biology, stress-related symptoms, personality traits/disorders, and the effects of insufficient learning experiences (Underlearning).⁵

In addition, the stage of an individual's recovery, independent psychiatric illnesses and resiliency factors must be understood to develop an individualized treatment plan.

Biology

Nearly 5,000 babies (one in every 750) are born with fetal alcohol syndrome (FAS),⁶ which is one of the top three known causes of birth defects with accompanying mental retardation (and the only preventable one).⁷ Anecdotal reports indicate the rate of FAS among selected Native American populations may approach 50%. FAS is not just a childhood disorder. While the typical facial deformities may fade, adolescents and adults with FAS continue to exhibit a recognizable pattern of low IQ (particularly in math), attentional deficits and problems with abstraction that frequently contribute to significant conduct disorders.⁸ Fetal alcohol effects (FAE, a lesser form of FAS) may affect 36,000 newborns each year.⁹ The role of FAE in producing the high level of childhood hyperactivity found in adults with alcoholism remains unclear.

A variety of research approaches strongly suggest that some children of alcoholics are at increased risk of their own alcoholism on the basis of genetic inheritance. Family studies consistently demonstrate increased

concordance for alcoholism in first-degree relatives of alcoholics.¹⁰ Monozygotic twins have approximately twice the concordance of dizygotic twins.¹¹ Adoption studies, which found 4-9 times the normal rate of alcoholism in the male offspring of male alcoholics, provide the strongest argument that these increased concordance rates are on the basis of genetic transmission.¹² Research into potential neurophysiological and biochemical markers is actively exploring the precise nature of this genetic transmission. P300 event related potentials are reduced in boys with alcoholic fathers, and may be a predictor of increased risk of alcoholism.¹³ There is also less subjective reaction, less loss of motor control, and less increase in blood cortisol levels in males who are family history positive for alcoholism when challenged by a dose of alcohol.¹⁴

Stress Factors

A conservative estimate of 675,000 children are seriously mistreated annually by an alcohol- or other drug-abusing caretaker, which means that one out of every 13.3 children with a chemically dependent parent is seriously abused every year.¹⁵ Studies document that young COAs exhibit more symptoms of generalized stress, including low self-esteem, increased arousal and feelings of a lack of control over their environment.¹⁶ Documented cognitive disruptions, most notably deficits in abstraction/conceptual reasoning and verbal abilities,¹⁷ may also be due to high levels of stress.

On a clinical level, many adult COAs exhibit elements of Post Traumatic Stress Disorder (PTSD). Blatant dissociation is frequent, as is psychic numbing and amnesia for large portions of childhood. On the other hand, symptoms of re-experiencing the trauma also occur, with ruminations, inability to control intrusive thoughts regarding one's family of origin, and re-emergence of raw feelings, thoughts, and behavior

in response to situations which symbolically resemble earlier, traumatic experiences. Generalized hypervigilance and survival guilt also commonly exist in COAs. Three points relevant to stress-related symptoms are important. First, the stress does not have to be overt physical or sexual abuse. It can come from a pervasive pattern of being ignored, threatened, and rejected by an intoxicated parent who has extremely tenuous self-control and little respect for appropriate boundaries between parent and child. Second, stress-related symptoms are best understood through the framework of Trauma Theory, rather than being interpreted through the framework of Drive Theory, as forcefully argued by Alice Miller.¹⁸ Third, stress-related sequelae must often be treated first, before psychotherapy designed to produce characterological change can be tolerated long enough to be effective.

While a few COAs do suffer from full-blown PTSD, the majority do not, which leaves their stress-related characteristics poorly diagnosed within the framework of DSM-III-R. Especially for young COAs, the suggested diagnostic category of Chronic Trauma Disorder (CTD) of Childhood/Adolescence¹⁹ holds promise. By combining a history of impaired family functioning with stress-related disruptions in cognition, behavior, mood, interpersonal relationships and hyperarousal, CTD takes into consideration the complex impact of stress on the process of child development. It is the result of this interaction between normal developmental forces and stress-related characteristics which creates the personality pathology seen in many adult COAs.

Personality Traits/Disorders

Not all personality pathology stems from trauma. Much stems from a child's personality molding itself to fit into the only relationships available, i.e., with parents who are

themselves personality disordered. Research establishes that young COAs have increased rates of behavior problems (e.g., lying, stealing, fighting, truancy and school behavior problems) and can be significantly more impulsive, overactive, anxious, and depressed.²⁰

A particularly elegant research approach demonstrates that children of alcoholics, *and their mothers*, frequently underestimate their school competence, thereby affecting the child's motivation, self-esteem and future performance.²¹ It is in the area of personality traits and disorders that the phenomenon of co-dependence needs to be addressed. Few concepts in recent memory have been bandied about by the public and excoriated by professionals as much as co-dependence. My approach has always been to as-

This Is my understanding of co-dependence and its relevance to clinical practice.

sume that the narrative literature²² regarding co-dependence produced by the public is describing an important aspect of people's experience, but that it takes considerable effort to comprehend what this experience means on a psychodynamic level. In the next four paragraphs, I summarize my understanding of co-dependence and indicate its relevance to clinical practice.

Many people have noted the common features seen in family members of alcoholics (e.g., denial, assuming responsibility and feeling embarrassment for other's behavior, lack of entitlement). These features are generally the antithesis of narcissism (remember that the opposite sides of a coin represent the same currency). It is no secret that

(continued on p. 6)

Children of Alcoholics (*continued*)

active alcoholics generally develop a functional narcissism (the word "functional" means that the narcissism is an overlay on their basic personality structure, resulting from a combination of a drinking life style and the biochemical effects of alcohol, especially on the frontal lobe). The grandiosity and self-centeredness of alcoholics is the hand for which family members must mold

Just as narcissistic traits can intensify into an overt disorder, so too can co-dependence.

themselves into a glove, if they are to remain in relationship. Young children, of course, have no choice regarding whether to be bonded to, and in relationship with, parents, whether the parent is alcoholic or not. Such bonding is a biological imperative.

As the myth of Narcissus and Echo tells us, the only way to remain in relationship with someone who is narcissistically disordered is to become the perfect mirror. Echo performed this feat by speaking only the words Narcissus uttered first. Co-dependence is a label for the personality traits which are complementary to narcissism; and, just as narcissistic traits can intensify into an overt disorder, so too can co-dependence.

Heinz Kohut²³ wrote that infants have two primitive interpersonal needs: the need for unconditional regard (the Narcissistic need) and the need to merge with the benevolence and power of one's parent (which I have labeled the Echoistic need). When these two needs develop normally, the narcissistic need becomes the source of self-esteem and the echoistic need becomes the source of empathy. In order to develop normally, these needs must first be gratified, and then frustrated in age-appropriate

ways. Such gratification and optimal frustration are unlikely to occur with an alcoholic parent. Instead, in order to remain in relationship with the alcoholic parent, children must become mirrors by disowning their normal narcissistic needs and keeping their echoistic needs in their primitive, ungratified form. The result is a co-dependent personality structure.

When co-dependence is recast as echoism and seen as the complement of narcissism, it contributes

clarity to traditional psychodynamic theory. I have developed diagnostic criteria (see box) that clearly delineate the disorder and contain significant clinical implications. For example, transference in echoistic patients commonly causes them to approach therapists as narcissistic personalities who have to be appeased to avoid being abandoned. In addition, the treatment goals in echoism are to help patients reown their normal narcissistic needs and to mature their primitive echoism.

Proposed Diagnostic Criteria for Co-dependence (Echoism) Based on Complementarity with Narcissism

Co-dependence is a pervasive pattern of inadequacy (in fantasy or behavior), excessive empathy, hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

1. Reacts to criticism with feelings of fear, shame, or embarrassment (even if not expressed)
2. Is interpersonally exploited: permits others to take advantage of him or her to achieve the others' own ends
3. Has an inadequate sense of self-importance, e.g., minimizes achievements and talents, expects to be ignored except insofar as achievements are continuously present
4. Believes that his or her problems are unique and can be understood only by other special people
5. Is preoccupied with fantasies of unlimited failure, impotence, catastrophe, evil, or ideal love
6. Lacks a sense of entitlement: unreasonable expectation of especially unfavorable treatment, e.g., assumes that he or she must wait in line in order for others to be taken care of first
7. Constant desire for attention and admiration, e.g., keeps fishing for compliments, but has a highly developed capacity for delayed gratification
8. Lack of empathy for him or herself, in conjunction with excessive empathy for others: inability to recognize and experience how he or she feels
9. Is preoccupied with feelings of guilt

Cermak, T. *Evaluating and Treating Adult Children of Alcoholics*, Volume I. Minneapolis: Johnson Institute Publications, 1990, p. 130.

Underlearning

Adults COAs often complain about not knowing what is normal. While this can be a classic manifestation of resistance to therapy, it may also be the simple truth. Children of alcoholics often have a profound lack of modeling, which leads them to reach adulthood without having had many experiences which the average American has had during childhood.

For example, many COAs have never seen an argument resolved and lead to greater intimacy; many

Research has documented that alcoholism is transmitted more frequently to the next generation in families where parents do not consistently set and follow through with plans or maintain such rituals as holidays and regular mealtimes

have never seen anger in a parent without violence; many have never seen an adult with a good work ethic, an extended family gathering, a family vacation, or even a dinner when the entire family sat down together. Research has documented that alcoholism is transmitted more frequently to the next generation in families where parents do not consistently set and follow through with plans or maintain such rituals as holidays and regular mealtimes.²⁴

Stage of Recovery

"Recovery" refers to the gradual re-emergence from chronic intoxication and the alcoholic lifestyle that can occur with sobriety. In order for recovery to deepen, most alco-

holics must explore how denial has suffused their lives, relinquish the grandiosity which propels their relationship to willpower, and enter into relationships from a less self-centered posture. Such changes are not easy. The success of Alcoholics Anonymous comes from providing a community of recovering alcoholics that supports and leads people through this process.

Since children of alcoholics learned much of what they know about denial, willpower and relationships at the knee of an alcoholic, they are often greatly helped by tracing through the same recovery steps that work for alcoholics. Understanding and respecting recovery permits therapists to evaluate the blockages and successes a COA patient has encountered in this process. It also enables therapists to tailor their treatment to the specific dynamics that were encountered by a child growing up in an alcoholic family.

Resiliency Factors

While all children of alcoholics are *affected* by their experience, and many are damaged, the majority emerge relatively intact. Recent research has focused on the factors contributing to such resiliency.²⁵ Still in its infancy, this work has begun to outline the positive interaction which can occur between protective factors which exist in some COA's environments and the temperament and coping mechanisms that emanate directly from a child. For example, alcoholic families which are able to maintain rituals and ties to the extended family can be far less toxic than alcoholic families which simultaneously disintegrate internally while isolating the children from contact outside the family. Similarly, children with temperaments which fortuitously promote both independence and pleasing interactions with others are more likely to meet the challenge of their alcoholic environment rather than be overwhelmed by it.

Conclusion

The children of alcoholics represent a heterogeneous, but identifiable, population that more often than not benefits from the breaking of denial that occurs with accepting the label. When this label is converted into a facile "diagnostic" impression or is used as an excuse for continued immaturity, its value has been aborted. However, when the label serves as a blueprint for exploring the range of experiences and their long-term impacts that growing up with an alcoholic parent commonly present, it is an invaluable part of the therapeutic process.

Finally, there is no greater balm to past wounds than to find meaning within the experience of trauma. Despite the considerable media attention paid to children of alcoholics during the past decade, precious little has changed (especially for young COAs). It is not helpful when professionals denigrate the clamoring of victims to pay more attention to their plight, and the ongoing plight of the 9-10 million children currently living with a chemically dependent parent. As strident, or unsophisticated, as this clamoring may be at times, it is born from a combination of legitimate pain, the reowning of normal narcissistic needs, and the almost undying human search for meaning.

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Letter to the Editors

Re: Buprenorphine Treatment of Opiate Dependency
Walter Ling, MD and Donald Wesson, MD
CSAM NEWS, Winter 1992, 19(3): 18-19.

In the Seattle area, buprenorphine is also available in a flavored gelatin troche form made by two local pharmacies on special request. The troche is available in both 0.3 mg and 0.6 mg strengths and is scored for tapering purposes.

In the inpatient setting, the buprenorphine troche is used for opiate withdrawal either by itself or following IM buprenorphine. In general I begin buprenorphine 24 hours after clonidine oral and/or patch therapy. The buprenorphine ameliorates the muscle and abdominal aches and cramps.

I use buprenorphine for a period of 4-5 days and then discontinue. I have found no problems with buprenorphine withdrawal. One concern is some patients, once started on buprenorphine, begin to request it regularly.

One outpatient center has reported good results using the troche for approximately two weeks for opiate withdrawal. Initial dosage can be up to 0.6 mg troche q 4-6 hours for the first 3-4 days.

The troche is dissolved in the mouth and the buprenorphine is absorbed through the mucosa. A reported problem has been buccal mucosal irritation. It is not clear whether this is due to the buprenorphine or the flavorings.

A benefit of the troche form is to move away from continued use of needles to administer medication during detoxification. Treatment staff members have expressed concern that needles may serve as triggers during this volatile period in treatment.

One consideration is that problems with the troche lead to discussion of outpatient IM use. One patient has admitted using the buprenorphine to abate opiate withdrawal in order to have time to get heroin from more "reliable" and less risky sources.

Buprenorphine is a Schedule V narcotic agonist/antagonist which shows promise in opiate withdrawal. Time and frequent communication will help addictionists learn its place in both the inpatient and outpatient treatment of opiate dependency.

Bill Dickinson, DO
Medical Director
Careunit Hospital of Kirkland, WA

Tuberculosis in Substance Abusers

Karen Lea Sees, DO

The persistent downward trend in the rate of tuberculosis in the United States has ended. Between 1985 and 1991, there was an 18.4% overall increase in reported active tuberculosis cases. In some areas the increase was even greater: 23% in San Francisco and 80% in New York City. In addition, there are currently 10-15 million cases of latent tuberculosis; these are in persons who have a positive skin test for tuberculosis but have no evidence of active infection.

Not only has the incidence of tuberculosis in general increased, but, more alarmingly, so has the incidence of multidrug-resistant tuberculosis (MDR-TB). Treatment of MDR-TB is more demanding—both in terms of the cost of a dose of the medication(s) used and the length of time the medication(s) must be taken (18-24 months compared to 6-12 months for non-drug-resistant TB)—and

Patients and treatment providers are at risk.

mortality rates are higher than for non-drug-resistant TB. In HIV-positive individuals, the mortality rate for MDR-TB is 70-90% with the time from diagnosis to death averaging 4-16 weeks.

Several factors contribute to the increase in the incidence of tuberculosis: the increasing number of immunocompromised persons (the majority of whom have HIV disease), the expanding homeless population, overcrowded homeless shelters, rising and overcrowded jail population, high incidence of drug abuse, increasing numbers of people without access to health care, high rates of immigration from TB-endemic countries, especially Asia, and decreased attention to tuberculosis over the past several decades due to its apparent demise.

Substance abusers often fall into several of these high-risk categories, further increasing their risk for tuberculosis. In 1992, 35% of the patients in the Substance Abuse Treatment Clinic at the San Francisco VA Medical Center (SFVAMC) were skin-test positive for tuberculosis with no history of prior isoniazid (INH) prophylaxis, and there was one case of active tuberculosis. Not only are substance abuse patients at risk, but treatment providers are also at risk. In 1992, two staff in the Substance Abuse Service at the SFVAMC converted from PPD negative to PPD positive.

Not only has the epidemiology of tuberculosis changed, so have the guidelines for testing and treating both latent and active disease. At a minimum, all patients in substance abuse treatment, unless they have previously

tested positive for tuberculosis, should receive a skin test yearly using the Mantoux Technique (intradermal injection of .01 ml of purified protein derivative [PPD] containing 5 tuberculin units [TU]). The Tine Test (four-pronged premade applicator) is not recommended. If feasible, PPD skin-testing should be done in this patient population every six months.

PPD testing at least once a year is the recommendation for all PPD-negative health care providers who have contact with patients. Substance abuse treatment staff and high-risk individuals (patients and staff) such as those who are immunocompromised (e.g., HIV +, cancer, frequent steroid use, recent rapid weight loss) should get a PPD test every six months. This is especially important for substance abuse treatment providers if their patient population has a high incidence of positive PPD test results or a high incidence of active tuberculosis. We risk our own health, the health of other employees, and also the health of many patients (especially those who are immunocompromised) by not being tested and treated if we are PPD positive.

Knowing the HIV status of the person tested is important for reading PPD results and for determining the duration of treatment for both PPD positive individuals and those with active disease. For the general population, a positive skin test is a reaction of palpable induration of 10 mm, but for those who are HIV + palpable induration of equal to or greater than 5 mm is considered positive.

The guidelines for INH prophylaxis have also changed. The age exclusion criteria are not used as often. Fifty- and 60-year-old individuals are frequently now treated. PPD converters, even those who converted in the remote past but never took prophylactic INH, and those who are older than 35 years of age, should be evaluated for prophylactic INH treatment. INH prophylaxis is recommended for a minimum of six months in individuals who are not health care providers, not immunocompromised, and who have no contraindication to the treatment. For individuals who are health care providers and/or immunocompromised and where there is no medical contraindication to treatment, INH prophylaxis should be taken for a full 12 months. □

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Doctor Sees is Assistant Chief of the Substance Abuse Treatment Clinic, San Francisco VAMC.

Diversion Program

By now, California Society members have received my recent letter describing the California Highway Patrol's investigation of allegations regarding the Diversion Program of the Medical Board of California (MBC).

The California Society does not and should not voice an opinion on the events which precipitated the investigation. However, our mission demands that we make every effort to ensure that chemically dependent patients, including those who are physicians, are not funneled to the disciplinary system and punished for having the disease of chemical dependency.

The shunting of doctors into the disciplinary system of the Medical Board was long ago proven to be wasteful, ineffective and a disservice to the public and the afflicted physician alike.

For all its current difficulties, California's Diversion Program for Physicians has:

1. created another mechanism for rapidly removing physicians from the workplace if they posed an immediate danger to patient care. The alternative mechanism is for the Board to obtain a temporary restraining order from the courts—a more expensive and time consuming (and potentially patient endangering) process.
2. saved the taxpayers large sums of money by not underwriting expensive disciplinary proceedings against physicians whose only violation of the Medical Practice Act was chemical dependence.
3. salvaged the careers of hundreds of physicians who would have otherwise been lost to the profession.

The record of California's Diversion Program is very good. Since it began in 1980, 390 physicians have been successfully "graduated," and 236 are currently enrolled. A recent article reported that of the physicians who have enrolled, 72% have completed the program successfully.¹ This compares favorably to the 75% completion rate achieved by the State Board administered program in our neighboring state of Oregon.²

California needs a viable, credible physician diversion program. We owe it to our patients, our colleagues and the public to assure a rapid and effective response to physician impairment and expert professional evaluation, treatment and follow-up for the physician. This goal will be a major focus for my remaining tenure as president.

REFERENCES

1. Ikeda, R and Pelton, C. Diversion programs for impaired physicians. *Western Journal of Medicine*; 1990, 152:617-621.
2. Shore, J. The Oregon experience with impaired physicians on probation. *JAMA*; 1987, 257:2931. □

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 Hansen, MD, is Senior Flight Surgeon at the North Island Naval Air Station in San Diego. He graduated from the Medical College of Virginia in 1974, and completed a residency at Harvard University in 1977. He is taking Boards in Aerospace Medicine in the fall of 1993.

John Harsany, Jr., MD, is an internist in private practice in Hemet and is Medical Director of the Riverside County Alcohol Program. He graduated from the University of Alabama School of Medicine in 1968 and completed a residency which included three years at Gorgas Ancon Hospital in the Canal Zone, in 1971.

Harry Hoffman, MD, is a board-certified radiologist with the Sleepy Hollow Medical Group in Laguna Beach. He graduated from Northwestern University School of Medicine in 1961 and completed a residency at Johns Hopkins in 1965. Doctor Hoffman was a radiology research fellow at Johns Hopkins in 1965-66, and a neuroradiology fellow at UCSF in 1970-71.

Michael Horwitz, MD, a board-certified internist, is Acting Director of the Division of Alcoholism and Substance Abuse and Acting Medical Director of the Center for Chemical Dependency at Cedars Sinai Medical Center in Los Angeles. He graduated from George Washington University School of Medicine in 1982 and completed a residency at Cedars Sinai in 1985.

Norman Reynolds, MD, is a board-certified psychiatrist in private practice in San Jose. He graduated from Stanford University School of Medicine in 1968 and completed a residency there in 1972. He was recently appointed to the Sixth Diversion Evaluation Committee for California's Diversion Program for Physicians.

Ted Welton, MD, an internist, is Assistant Medical Director at St. Joseph Hospital Family Recovery Center in Eureka. He graduated from the University of Iowa School of Medicine in 1953. He did three years in an internal medicine residency at the US Public Health Service Hospital from 1955 to 1958. □

NEWS ABOUT MEMBERS

Stephen Fisher has left his private practice of psychiatry and will devote his time to the Asian Community Mental Health Center in Oakland's Chinatown and at East Oakland Mental Health Center.

Richard Bowdle is now serving as Director of Managed Care at CPC Laguna Hills in addition to his private practice of psychiatry in Laguna Hills.

William Brostoff was elected a Fellow of the American College of Physicians.

Laurie Buchfuhrer of Long Beach reports that she is now serving as the Medical Director of an addiction program called "Woman to Woman."

Karl Buretz has moved from Rancho Mirage to Saudi Arabia where he is Director of Medical Services for the Peace Sun Medical Clinics in Riyadh.

William Hazle is the Program Director for Addiction Medicine at CPC Fremont.

Lloyd Hyndman is now serving as a staff psychiatrist for Alcohol and Drug Treatment Services at the Com-

munity Mental Health Center for San Luis Obispo County.

Charles Klingsberg is now Medical Director for Vista Recovery Centers in Anaheim and is working with Avalon Adolescent Program at CPC Psychiatric Hospital in Brea.

Howard Kornfeld is a consulting physician for addiction medicine with CPC Walnut Creek.

Jerome Lackner is a consultant to the Chemical Dependency Program at Charter Hospital in Sacramento.

Robert Lawrence is on the Alcoholism Council of Antelope Valley near his home in Lancaster.

Arthur Lingousky is now working at Westside Community Mental Health in San Francisco.

Joel Nathan is the Chief of the Chemical Dependency Recovery Program at Kaiser Anaheim.

Garrett O'Connor has closed his 10-year-old outpatient treatment program, REPAIR (Rehabilitation for Alcoholics/Addicts Interested in Recovery) to concentrate on his evalua-

tion and referral practice of addiction medicine and psychiatry in Los Angeles and his teaching and writing on native Irish and American-Irish experience.

Melvin Pohl is serving as the Clinical Medical Director at Montevista Hospital in Las Vegas.

James Pratty is the Medical Director of Psychiatric Services at Bellflower Doctors Hospital.

Barry Rosen is serving as the Medical Director of the Russian Project for SALUS International Health Institute.

Calinica Semense is working part time at the Chemical Dependence Recovery Program at Kaiser Carson. **Harold Zelman** has recently retired from his position as a staff physician there.

Glenhall Taylor is serving as a consulting psychiatrist in the Drug and Alcohol Program at Kaiser Sacramento.

Michael Turek is the Medical Director for Outpatient Services at Charter Hospital in Thousand Oaks. □

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For information, contact Martin W. Adler, PhD, Department of Pharmacology, Temple University School of Medicine, 3420 North Broad Street, Philadelphia, PA 19140.

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For information, contact Debra Sharp, 4314 Medical Parkway, Suite 300, Austin, TX 78756; 512/454-0022.

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