DOCTORS AND DRUNKS:

ADDICTION MEDICINE AND ADDICTION PSYCHIATRY IN AMERICA

by

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ABSTRACT

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Two distinct medical disciplines treat addiction in the United States: addiction medicine and addiction psychiatry. This dissertation examines the professional competition between addiction medicine and addiction psychiatry to "own" the medical treatment of addiction. The field of addiction medicine originated in 1954 and grew rapidly between the 1960s and 1980s, attracting doctors recovering from alcoholism and drug abuse and loyal to Alcoholics Anonymous. Addiction psychiatry was born in 1985 when academic psychiatrists, who eventually won recognition from the American Board of Medical Specialties, questioned what doctors in recovery knew medically about substance abuse besides what they learned in Twelve-Step treatment. Drawing on semi-structured interviews with prominent addiction medicine physicians, addiction psychiatrists, and former officials from both fields, in addition to historical documents on the development of addiction medicine and addiction psychiatry, this dissertation shows how scientific knowledge generates institutional power in organized medicine. Addiction psychiatry owns the medical treatment of addiction institutionally due to its academic base, abstract and formal

knowledge, and subspecialty recognition from the American Board of Psychiatry and Neurology. Addiction medicine, stigmatized by its tradition of physicians in recovery, owns the medical treatment of addiction ideologically due to the ubiquity of Twelve-Step care.

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ORGANIZATION ACRONYMS

ASAM
American Society of Addiction Medicine

AA
Alcoholics Anonymous

NCEA
National Committee for Education on Alcoholism

AMA
American Medical Association

NCA
National Council on Alcoholism

AMSA
American Medical Society on Alcoholism

CMA
California Medical Association

AMSAODD
American Medical Society on Alcoholism and Other Drug Dependencies

AAPAA
American Academy of Psychiatrists in Alcoholism and Addictions

AAAP
American Academy of Addiction Psychiatry

GAP
Group for the Advancement of Psychiatry

Let us constantly remind ourselves that … the practice of medicine is for physicians; and that we, the recovered alcoholics, are their assistants.

—Bill Wilson, co-founder of Alcoholics Anonymous

INTRODUCTION

On March 29, 2007, Senator Joseph R. Biden, Jr. (D-DE), a U.S. Senator for 35 years, two-time presidential candidate, and currently Chair of the Senate Judiciary Subcommittee on Crime and Drugs, issued a press release to announce legislation that would rename America's most powerful centers for substance abuse research. Biden's bill proposed to change the National Institute on Drug Abuse to the National Institute on Diseases of Addiction, and to change the National Institute on Alcohol Abuse and Alcoholism to the National Institute on Alcohol Disorders and Health. With bipartisan support from Senators Edward M. Kennedy (D-MA) and Michael B. Enzi (R-WY), Biden argued that the names of these institutions should reflect the medical and scientific knowledge that their combined $1.5 billion budget supports. In the press release, Biden explained that:

> Addiction is a neurobiological disease—not a lifestyle choice—and it's about time we start treating it as such. We must lead by example and change the names of our Federal research institutes to accurately reflect this reality. By changing the way we talk about addiction, we change the way people think about addiction, both of which are critical steps in getting past the social stigma too often associated with this disease (2007).

Biden's description of addiction as a neurobiological disease and his call to integrate the words "disease," "disorders," and "health" into the names of the nation's top addiction research centers show very clearly the dominance and still growing power of the medical profession's authority over addiction. One need only browse

popular newspapers, magazines, and internet news sites to see articles on pills that prevent brain chemicals from producing drug euphoria, monthly medicinal injections for alcoholics, and vaccines that block the effects of cocaine and nicotine (see Hitti 2005a; Hitti 2005b; Jewell 2005; Rubin 2005; Talan 2006; The Associated Press 2007; Waknine 2006; Windham 2004). Other stories discuss electrode brain implants that control drug cravings, physicians who perform lobotomies on heroin abusers, and doctors who suggest that induced amnesia will help addicts forget about drugs (see Adam 2004; Bouchez 2004; "Brainwashing" 2005).

Medical treatments vary, but these and similar media reports make it appear as if most physicians treat substance abuse and that, fundamentally, the medical profession is unified in its approach to addiction. Although widespread, this understanding is not accurate. In actuality, two distinct and competing medical disciplines treat addiction in the United States: one is called addiction medicine and the other is called addiction psychiatry.

Addiction medicine was born in the early 1950s when a New York City internist named Ruth Fox, whose husband was an alcoholic, and Marty Mann, the first woman to stay sober with the Alcoholics Anonymous Twelve Step program of recovery, created an organization of physicians interested in alcohol addiction called the New York City Medical Society on Alcoholism. The New York Society promoted the new understanding of alcoholism as an illness that Alcoholics Anonymous invented. A number of physicians in the New York Society were themselves recovering alcoholics who received poor treatment from psychiatrists and

turned to Alcoholics Anonymous for care. Addiction damaged the medical career of many of these physicians, but their personal recovery reenergized their professional interests.[1]

As the New York Society gained national stature, the field of "addiction medicine" attracted more physicians recovering from drug abuse, none as influential as G. Douglas Talbott. A self-described "addictionologist," Talbott revived his medical career by treating other addicted physicians with the Alcoholics Anonymous Twelve Step program and forming the American Academy of Addictionology, an organization that supported doctors in recovery who pursued a career in drug treatment. Talbott believed that addictionologists filled a longtime gap in medical care for addicts and that personal recovery qualified addictionologists as treatment experts. In fact, Talbott wanted the American Board of Medical Specialties, the "gold standard" of physician credentialing (see American Board of Medical Specialties N.d.), to recognize "addictionology" as a medical specialty.

A medical specialty in addictionology, however, would have shattered the field of addiction medicine, which by the early 1970s consisted of the American Medical Society on Alcoholism (formerly the New York Society), the American Academy of Addictionology, and the California Society for the Treatment of Alcoholism and Other Drug Dependencies. Addiction medicine could not become a credible field of medicine with three separate and sometimes rival constituencies. Forced to unify, doctors recovering from addiction worked beside physicians with a strictly professional interest in drug treatment. Today, the leading organization in

addiction medicine, the American Society of Addiction Medicine (ASAM, pronounced A-SAM), has about 3,000 members. According to reliable estimates from prominent ASAM officers and former officials, approximately one-third of ASAM's members are in recovery from addiction.

Addiction psychiatry comes from very different roots. This discipline originated in the mid-1980s when a small group of academic psychiatrists from the American Psychiatric Association, led by Drs. Richard Frances and Sheldon I. Miller, founded their own organization of addiction specialists called the American Academy of Psychiatrists in Alcoholism and Addictions. The psychiatrists believed that substance dependence was a mental illness which they could treat far more effectively than addiction medicine physicians, especially recovering addictionologists whom they psychiatrists claimed replaced them at the forefront of treatment.[2]

In 1991, addiction psychiatrists pointed to their scholarship on drug abuse, the scientific literature that linked addiction to mental illness, and exclusive substance abuse training programs for psychiatrists to persuade the American Board of Psychiatry and Neurology that they possessed a body of specialized knowledge on addiction. This won the psychiatrists subspecialty recognition from the American Board of Medical Specialties, giving addiction psychiatry substantial status and power in the medical field of addiction treatment. Addiction medicine, in contrast, holds no specialty or subspecialty status in organized medicine.

According to Abbott, "it is the history of jurisdictional disputes that is the real, the determining history of the professions. Jurisdictional claims furnish the impetus

and the pattern to organizational developments" (1988:2). Professional competition between medical groups, for instance, is tied to the production, dissemination, and control of specialized knowledge (see Abbott 1988). For example, late nineteenth century ophthalmologists accused opticians of providing eye exams without medical training. When opticians countered that ophthalmologists lacked the specialized knowledge to perform the same service, ophthalmologists began certifying themselves as trained medical "specialists" (see Rosen [1944] 1972; Stevens 1998). Orthopedic surgeons who treated disabled World War I veterans added "vocational rehabilitation" (Gritzer and Arluke 1985:43) to their list of qualifications after industrial physicians argued they too could care for the war wounded and also help them find jobs. In the 1960s, after endocrinologists and cardiac surgeons challenged the medical authority of pediatric physicians from both fields, the pediatric specialists created board certification exams to highlight their specialized skills. The pediatric specialists acted "in response to competitive pressures generated by contemporary medical segments" (Halpern 1988:127).

Similarly, psychiatrists with a scholarly and clinical interest in addiction were troubled by what addiction medicine physicians and doctors in recovery knew medically about substance abuse in the absence of training programs in addiction medicine and board recognition for the field. Even today, addiction psychiatrists contrast their scientific knowledge, codified by board subspecialty status and specialized training, with their contention that addiction medicine physicians, specifically doctors in recovery, conceptualize addiction and drug treatment based on the Twelve Step program of Alcoholics Anonymous.

Gusfield (1981; 1989) suggests that professional groups compete for "ownership" of social problems like addiction. "It is here," Gusfield says, "that knowledge and politics come into contact" (1981:15). This dissertation traces the competition between addiction medicine and addiction psychiatry to "own" the medical treatment of addiction. Chapter One examines the group of recovering alcoholics, physicians, and scientists who convinced the American Medical Association in the 1950s that alcohol addiction was an illness. Chronic drunkenness became a medical problem only after it was modernized by the "alcoholism movement." Chapter Two links the alcoholism movement to physicians in New York and California who established the field of addiction medicine. Some of these doctors were former addicts. Others argued that addiction medicine's rapid growth signaled that the field deserved mainstream medical status.

In the 1970s, American medicine acknowledged drug abuse among medical professionals. Chapter Three details the impact of "impaired physicians" on addiction medicine. Physicians in recovery, particularly addictionologists affiliated with G. Douglas Talbott, compelled the field of addiction medicine to unify under one national organization. The American Medical Association subsequently endorsed addiction medicine as an official medical discipline, but the American Board of Medical Specialties did not follow suit.

The fourth chapter traces the origins of the addiction medicine certification exam in the 1980s and its import to addiction medicine's professional standing and cohort of recovering addicts. Chapter Four also addresses training deficiencies in

addiction medicine which underscore experiential knowledge and diminish the field's medical status.

Chapter Five turns to addiction psychiatry. In the 1980s and early 1990s, psychiatrists who studied and treated addiction felt overshadowed by addiction medicine physicians who were not properly trained to treat drug abuse, a portion of whom, the psychiatrists claimed, relied too heavily on the same Twelve Step program they used to recover. "For one profession to accept fully the right of another to handle its own clients is to deny its own charter" (Goode 1960:910). The psychiatrists questioned addiction medicine's appeal for recognition from the American Board of Medical Specialties while they acquired subspecialty status—and the "right to responsibility" for addiction treatment—from the American Board of Psychiatry and Neurology.[3]

Chapter Six compares how addiction medicine physicians and addiction psychiatrists define addiction and approach drug treatment to illustrate not only the "art" of addiction treatment but how medical professionals from both fields exploit the complexity of treatment to defend against encroachment from medical competitors.

"The organizational formalities of professions are meaningless unless we understand their context. This context always relates back to the power of the professions' knowledge systems, their abstracting ability to define old problems in new ways. Abstraction enables survival" (Abbott 1988:30). This dissertation concludes that addiction psychiatry owns the medical treatment of addiction

institutionally due to its academic base, abstract and formal knowledge, and subspecialty recognition from the American Board of Medical Specialties. Addiction medicine, stigmatized by its tradition of physicians in recovery, owns the medical treatment of addiction ideologically due to the pervasiveness of the Twelve Steps; more specifically, addiction medicine's origins in the Twelve-Step movement that Alcoholics Anonymous started, the American Society of Addiction Medicine has historically supported, and that, today, addiction psychiatrists criticize as professional competitors but endorse as medical clinicians.

Notes

[1] Physicians who were reformed drunkards first became prominent in the late nineteenth century. Starting in 1891, the Keeley Institutes, famous for their mysterious and likely phony Double Chloride of Gold remedy for alcohol and drug addicts, employed as many as 131 doctors with a history of addiction to alcohol, opium, morphine, or cocaine. Most of these physicians took to their medical duties within one year of having been treated themselves and some even sooner. These physicians ignited a controversy. Superintendents of treatment asylums did not approve of reformed drunkards as treatment providers. Dr. T. D. Crothers, for example, wanted to professionalize addiction treatment, and cure institutes like Keeley's competed with treatment asylums for patients, proceeds, and medical credibility. Crothers claimed that addicted physicians like those cured and hired by Keeley were mostly incompetent, with physical and mental "deficits" that severely limited their medical abilities and thus the professionalization and profitability of the addiction treatment field. Others claimed that the personal experience of recovering from addiction helped doctors better understand their patients' needs. By the 1920s, the debate over what role, if any, reformed physicians should have in addiction treatment was silenced by the Eighteenth Amendment and national alcohol prohibition. For more information, see Crothers, "Reformed Men as Asylum Managers" (1897); White, "The Role of Recovering Physicians in 19th Century Addiction Medicine: An Organizational Case Study" (2000b).

[2] I do not mean to imply that psychiatrists did not participate in addiction medicine and ASAM. In fact, ASAM currently reports that 27 percent of its members are board certified in psychiatry. See American Society of Addiction Medicine, *ASAM News* (2007). Still, the early opposition to addiction medicine came from psychiatrists whose professional loyalties were to their discipline's burgeoning role in addiction treatment.

[3] For a shorter piece on how addiction psychiatry won the "right to responsibility" for the medical treatment of addiction, see Freed, "Addiction Medicine and Addiction Psychiatry in America: The Impact of Physicians in Recovery on the Medical Treatment of Addiction" (2007).

CHAPTER ONE

THE MEDICALIZATION OF ALCOHOLISM

[I]f the medical profession were not to accept the idea of alcoholism as an illness, the movement for its propagation could not maintain itself in the long run, and would sooner or later collapse.

—E. M. Jellinek (1960:160)

The medical profession heals the sick so that they can fulfill their social roles and responsibilities (Parsons 1951a; Parsons 1951b). This is how illness is "made medical" (see Conrad 1992). But not all problems are medicalized by physicians; sometimes health care professionals are persuaded that certain problems are medical in nature and under their domain of expertise. Starting in the mid-1930s, a group of recovering alcoholics, physicians, and scientists constructed and disseminated the concept of alcoholism as an illness to foster public recognition of a condition which American medicine only later said existed. As Reinarman explains, "addiction-as-disease did not emerge from the natural accumulation of scientific discoveries…. The disease concept was invented … [and] promulgated by particular actors and institutions, and internalized and reproduced by means of certain discursive practices" (2005:308). Alcoholism became a medical problem only after it was "made medical" by specific, sometimes non-medical, individuals and organizations.

This chapter explores elements of the "alcoholism movement" (Johnson 1973) from 1934 to 1956, the year the American Medical Association called alcoholism an

illness for the first time. The modernization of chronic drunkenness, or what White calls "a radical redefinition of the nature of alcohol problems in America" (1998:178), was accomplished by an unusual group of actors and organizations including the psychiatrists William D. Silkworth and Harry M. Tiebout, William Griffith Wilson and Alcoholics Anonymous, the biostatistician E. M. Jellinek and the Yale Section of Alcohol Studies, and Marty Mann and the National Council on Alcoholism. They persuaded the American Medical Association and the public to endorse the idea that some individuals, for unknown reasons, suffered from a genuine illness called alcoholism.

Dr. William D. Silkworth and Alcoholics Anonymous

In 1934, a failed New York City stockbroker named William Griffith Wilson checked into Charles B. Towns Hospital for the third time. Towns Hospital was a private addiction treatment facility on New York City's Upper West Side that was operated by Charles B. Towns himself, a businessman and self-described medical pioneer with "the one as yet entirely successful known method of treating alcoholic addiction" (Towns 1917:114). Wilson, more commonly known as "Bill W.," was administered the Towns-Lambert treatment that Dr. Alexander Lambert made popular in the medical literature. "If some years ago any one had told me that it was possible to take away the desire for morphine, cocain, or alcohol in less than five days with a minimum of discomfort and suffering to the patient," Lambert wrote, "I should have felt justified in treating the statement with a polite skepticism. Such, however, is the fact, if [this] treatment … is carefully carried out" (1909:985).

The Towns-Lambert treatment consisted of "the persistent administration of [a] belladonna mixture in small doses and the thorough elimination by means of some form of mercury as a cathartic" (Lambert 1913:1933). In short, Wilson was treated with the extract from a hallucinogenic plant. Consequently, he experienced a "hot flash" about halfway through his hospitalization (Pittman 1988). "'If there is a God, let Him show Himself!'" Wilson cried out. "'I am ready to do anything, anything!' Suddenly the room lit up with a great white light. I was caught up into an ecstasy which there are no words to describe. It seemed to me, in the mind's eye, that I was on a mountain and that a wind not of air but of spirit was blowing. And then it burst upon me that I was a free man" (Alcoholics Anonymous World Services, Inc. [1957] 1971:63).

Wilson worried that this experience was treatment-induced delirium. He turned to psychiatrist William D. Silkworth for answers, Physician-in-Chief of Towns Hospital. Silkworth, "the little doctor who loved drunks" (A.A. Grapevine 1951), explained to Wilson that his hot flash was not a hallucination but a psychological conversion—a spiritual awakening that was powerful enough to cure his "hopeless" craving for alcohol (Alcoholics Anonymous World Services, Inc. 2001:xxv). Wilson, a lifelong agnostic, was only partially convinced. Then an old friend and recovered alcoholic named "Ebby" urged him to read *The Varieties of Religious Experience* by the philosopher William James, a mix of "religious impulses with other principles of common sense" (James [1902] 1999:xiv). Wilson "devoured it from cover to cover" (Alcoholics Anonymous World Services, Inc. [1957] 1971:64) and came to see his hot flash as a deflation of character, caused by suffering, which led to his acceptance

of a "Higher Power." Ebby's visit to Wilson was significant: it corroborated Silkworth's assessment of Wilson's experience and underscored the positive impact of one alcoholic talking to another. According to Wilson:

> On Dr. Silkworth's say-so alone maybe I would never have completely accepted the verdict, but when Ebby came along and one alcoholic began to talk to another, that clinched it. My thoughts began to race as I envisioned a chain reaction among alcoholics, one carrying this message and these principles to the next. More than I could ever want anything else, I now knew that I wanted to work with other alcoholics (Alcoholics Anonymous World Services, Inc. [1957] 1971:64).

Kurtz suggests that "the whole of what became Alcoholics Anonymous appeared in these words—almost" (1979:21). Wilson's stay at Towns Hospital was also important because there he learned from Silkworth that alcoholics are physically allergic to alcohol. "The inevitable conclusion is that true alcoholism is an allergic state," Silkworth said, "the result of gradually increasing sensitization by alcohol over a more or less extended period of time. The constancy of the symptoms and progress is too fixed to permit any other explanation" (1937:251). Wilson was relieved. "[Silkworth] supplied us with the tools with which to puncture the toughest alcoholic ego, those shattering phrases by which he described our illness: *the obsession of the mind* that compels us to drink *and the allergy of the body* that condemns us to go mad or die" (Alcoholics Anonymous World Services, Inc. [1957] 1971:13).

Wilson left Towns Hospital "with a powerful and guilt-assuaging medical metaphor to understand what had happened to him" (White 1998:129). In the months that followed, however, he was struck by how difficult it was to deliver Silkworth's message to other alcoholics. Wilson again turned to his physician for advice. "You've got to deflate these people first," Silkworth said. "So give them the medical business, and give it to them hard. Pour it right into them about the obsession that condemns them to drink and the physical sensitivity or allergy of the body that condemns them to go mad or die if they keep on drinking" (Alcoholics Anonymous World Services, Inc. [1957] 1971:68). In the spring of 1935, Robert Holbrook Smith, a surgeon from Ohio known as "Dr. Bob," was the first person to receive Wilson's revised message. "I remembered all that Dr. Silkworth had said," Wilson recalled. "I just talked away about my own case until he [Dr. Bob] got a good identification with me, until he began to say, 'Yes, that's me, I'm like that'" (Alcoholics Anonymous World Services, Inc. [1957] 1971:68). In 1935, Wilson and Smith founded Alcoholics Anonymous.[1]

In 1939, Wilson, Smith, and other early members of Alcoholics Anonymous (AA) assembled their key documents into a book called *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism*. Dubbed the "Big Book" due to its size, the *Journal of the American Medical Association* first described the work as "a curious combination of organizing propaganda and religious exhortation … [with] no scientific merit or interest" ("Book Notices—Alcoholics Anonymous" 1939:1513). The Big Book included testimonials of AA's effectiveness from recovered alcoholics and praise from Silkworth himself in

a passage entitled "The Doctor's Opinion." "The subject presented in this book seems to me to be of paramount importance to those afflicted with alcohol addiction," Silkworth wrote. "I say this after many years' experience as Medical Director of one of the oldest hospitals in the country treating alcoholic and drug addiction" (Alcoholics Anonymous World Services, Inc. 2001:xxvii).

The Big Book's centerpiece was the Twelve Step program of recovery outlined in the chapter "How It Works." This path to "spiritual progress" asks alcoholics to admit their powerlessness over alcohol, believe in a Higher Power, acknowledge their personal limitations, apologize to those they affected, and "having had a spiritual awakening as the result of these steps, … carry this message to alcoholics, and … practice these principles in all … affairs" (Alcoholics Anonymous World Services, Inc. 2001:60) (see Table 1 for the Twelve Steps).[1]

Today, the Big Book is in its fourth edition and published in 43 languages (Alcoholics Anonymous World Services, Inc. 2001). Silkworth's account of Wilson's last stay at Towns Hospital appears in every one:

> In late 1934 I attended a patient who, though he had been a competent businessman of good earning capacity, was an alcoholic of a type I had come to regard as hopeless. In the course of his third treatment he acquired certain ideas concerning a possible means of recovery. As part of his rehabilitation he commenced to present his conceptions to other alcoholics, impressing upon them that they must do likewise with still others. This has become the basis of

[1] All tables in this manuscript are numbered in chronological order and appear at the end of the chapter in which they are cited.

> a rapidly growing fellowship of these men and their families. This man and over one hundred others appear to have recovered…. These facts appear to be of *extreme medical importance* [emphasis added]; because of the extraordinary possibilities of rapid growth inherent in this group they may mark a new epoch in the annals of alcoholism. These men may well have a remedy for thousands of such situations (Alcoholics Anonymous World Services, Inc. 2001:xxv-xxvi).

By 1941, AA had about 4,000 members (Johnson 1973). The fellowship's early, rapid growth was mostly due to a flattering article by journalist Jack Alexander (1941) in *The Saturday Evening Post*. Alexander described the philosophy of AA, the organization's history, and some of the alcoholics the fellowship had helped. According to Kurtz, "if Bill Wilson's or Dr. Bob's conversion marked the beginning of Alcoholics Anonymous, its nationwide diffusion was due in the first instance to a similar experience on the part of Jack Alexander" (1979:101).

Wilson reached out to physicians as media reports described AA's effectiveness. He addressed Maryland's Mental Hygiene Commission and the Yale Summer School of Alcohol Studies (see Kurtz 1979; W.W. 1945). In a 1944 speech to the Medical Society of the State of New York, Wilson declared that the sole purpose of AA is "to help other alcoholics to recover from their illness…. [W]e A.A.'s are beholden to you [physicians], how much we have borrowed from you, how much we still depend on you. For you have supplied us ammunition which we have used as your lay assistants—gun pointers for your artillery" (Bill W. [1944] N.d.:25,

32). Wilson attributed much of this help to Silkworth: "Dr. Silkworth taught us how to till the black soil of hopelessness out of which every single spiritual awakening in our fellowship has since flowered" (Alcoholics Anonymous World Services, Inc. [1957] 1971:13).

Dr. Harry M. Tiebout: "A Great Friend of AA"

In 1938, after spending six months at Bellevue Hospital in New York City, an alcoholic named Marty Mann was admitted to an upscale psychiatric treatment center in Greenwich, Connecticut called Blythewood Sanitarium (Brown and Brown 2001). Harry M. Tiebout, a psychiatrist and Blythewood's medical director, treated Mann. Tiebout promoted permanent abstinence from alcohol, disagreeing with other psychiatrists who claimed that chronic drunkards could drink "normally" after dealing with their psychological issues (Brown and Brown 2001; Hazelden Foundation 1999).

Mann relapsed several times under Tiebout's care. Desperate to help, Tiebout gave Mann a copy of the Big Book that he was asked to review before it went to press (Brown and Brown 2001). Mann reluctantly read the book but was comforted to learn that other people suffered from a similar condition. An essay Mann wrote entitled "Women Suffer Too" that first appeared in the second edition of the Big Book tells what happened next:

> Then the miracle happened—to *me!* It isn't always so sudden with everyone, but I ran into a personal crisis that filled me with a raging and righteous anger. And as I fumed helplessly and planned to get good and drunk and *show them*,

> my eye caught a sentence in the book lying open on the bed: 'We cannot live with anger.' The walls crumpled—and the light streamed in. I wasn't trapped. I wasn't helpless. I was *free*, and I didn't have to drink to 'show them.' This wasn't 'religion'—this was freedom! Freedom from anger and fear, freedom to know happiness, and freedom to know love (Alcoholics Anonymous World Services, Inc. 2001:206).[2]

Mann had a spiritual awakening similar to Bill Wilson. She was not mentally ill but physically sick. She was "allergic," as Drs. Silkworth and Tiebout believed, to alcohol. A few months later, Mann attended her first AA meeting at Bill Wilson's home in New York where Wilson himself became her sponsor (Brown and Brown 2001).

AA's Twelve Step program of recovery impressed Tiebout. "Instead of the scalpel, there was the AA program," he wrote. "Instead of the infected appendix being removed, the individual was told to stop drinking, or stated in another way, liquor was removed from his life" ([1956] 1999:125). This approach was refreshing to a psychiatrist who criticized psychoanalytic treatment for addiction. "To insist on treatment of the original causes," Tiebout argued, "is like focusing upon the cause of the life-threatening fever or upon the irritation leading to cancer. The cause and the origins are irrelevant to the immediate danger" ([1951] 1999:8).

After the repeal of prohibition in 1933, however, the etiology of addiction weighed prominently. Most physicians were reluctant to treat alcoholism because it was challenging and stigmatizing (Johnson 1973). "The attitude of medical

organizations might have been due to the influence of the general attitude of the public, which looked upon alcoholism more as a moral problem than a medical one" (Block 1959:475). As a result, physicians in the addictions were usually psychoanalytically-trained psychiatrists who analyzed the connection between conscious and unconscious thoughts, sexuality and behavior, and childhood experiences and adulthood (Shorter 1997).

"Superficial impressions to the contrary," Robert P. Knight insisted, "no excessive drinker is normal and well adjusted when sober. It is the purpose, therefore, of the period of psychiatric study to discover what the individual aspects of the problem are … and to evaluate the severity of the addiction and the possibilities for reconstruction of the personality" (1938:1444). Karl Menninger claimed that priests, social workers, and prohibitionists mistakenly link alcohol addiction to external life difficulties and diseased states. "If it were so," Menninger suggested, "we should all become alcoholics" (1938:147). Alcohol addiction is not a disease, he continued, but "a suicidal *flight from* disease, a disastrous attempt at the self-cure of an unseen inner conflict" (1938:147) that requires "a complete and thoroughgoing reconstruction of the entire personality" (1938:159). Giorgio Lolli believed that "addiction to alcohol often develops in individuals whose … problems are largely determined by the perpetuation of infantile neuroticism" (1949:405). Alcohol pacifies this underlying state by causing a "psycho-physiological" (1949:408) reaction whereby the drinker dismisses reality.

Tiebout declared that "as far as psychiatrists are concerned, a sizeable majority never quite make the grade. They always seem like fish out of water" ([1956] 1999:122). Tiebout proposed a solution:

> [W]e need more people who will report their experiences as practitioners so that gradually a body of accepted practice can slowly be acquired. The knowledge of that practice and the ability to apply it will enable the individual to be expert in the field. Not until he has that knowledge can he be called expert, no matter how thoroughly trained he may be in the same allied field ([1956] 1999:127).

One medical colleague and recovering alcoholic called Tiebout "a great friend of A.A." (see Alcoholics Anonymous World Services, Inc. [1957] 1971:245) and thus an important ally in the movement to medicalize alcoholism.[3]

E. M. Jellinek and Alcohol Science

In 1937, some of America's brightest thinkers on alcoholism, including Lawrence Kolb of the United States Public Health Service and Howard W. Haggard of Yale University, formed the Research Council on Problems of Alcohol. The Research Council (1940a) proposed a systematic program of inquiry to establish and disseminate the "facts" about alcohol, judging that "at present, there is lack of knowledge, confusion and an absence of intelligent social policy amounting almost to chaos" (1940c:433). The centerpiece of the Research Council's work was a review of

the scientific literature on drunkenness by Norman Jolliffe, a psychiatrist at Bellevue Hospital in New York.

Karl M. Bowman, Director of Psychiatry at Bellevue Hospital and chair of the Research Council's scientific committee, promoted Jolliffe's literature review. "From Bowman's point of view, the chief purpose [of the scientific committee] would be to raise money for Jolliffe's research" (Johnson 1973:237).[4] In 1939, the Carnegie Corporation awarded Jolliffe a $25,000 grant. Titled "The Study of the Effects of Alcohol on the Individual," Jolliffe's project was the Research Council's most important contribution to alcohol studies (Page 1988).

Jolliffe hired an unknown biometrician named E. M. Jellinek to manage the literature review. Without any professional knowledge about alcohol addiction or experience in the field, Jellinek cataloged and abstracted 3,000 scientific works using a makeshift system of coded cards and serial numbers (Page 1997).[5] His efforts produced two seminal works on alcoholism: *Alcohol Addiction and Chronic Alcoholism* (Jellinek 1942) and the "Classified Abstract Archive of the Alcohol Literature" (see Jellinek, Efron, and Keller 1953; Keller and Efron 1953).

Jellinek's hard work caught the eye of Howard W. Haggard. In 1941, when the literature review ended, Haggard invited Jellinek to join his Laboratory of Applied Physiology at Yale University. Haggard wanted to integrate physiological studies of alcohol with a social scientific approach (Page 1988). Jellinek, now an expert on alcohol studies, was ideal for the job. In 1943, Haggard added the Section of Alcohol Studies to his laboratory and named Jellinek the director.

Jellinek "did as much as anyone to advance the notion that alcoholism is a treatable disease, and he offered the post-Prohibition era its most plausible explanation of the condition's etiology" (Lender 1979:361). This enterprise began in 1945 after Jellinek reluctantly agreed to analyze data that the *AA Grapevine*, the official newsletter of Alcoholics Anonymous, collected about its readers' drinking patterns. "I have undertaken this work with great interest but also with many misgivings," Jellinek warned. "Statistical thinking should not begin after a survey or an experiment has been completed but should enter into the first plans for obtaining the data. In the questionnaire under consideration this requirement was neglected" (1946:5). Nevertheless, in 1946 Jellinek published a "phaseology of alcoholism" from the *AA Grapevine* data. He identified basic, intermediate, and compulsive phases in the drinking history of current AA alcoholics, all leading to a terminal phase, or a loss of control over drinking.

Jellinek described his results as "highly suggestive and interesting," but the questionnaire and research sample "superficial" (1946:78, 79).[6] He subsequently attached a revised questionnaire to his report which he then distributed to more than 2,000 male alcoholics. Once again, Jellinek identified four phases of alcoholism, but this time he used different terms to signify them: the prealcoholic symptomatic phase, the prodromal phase, the crucial phase, and the chronic phase. Jellinek argued that each phase was physiological in nature and led to a diseased state: "the onset of the 'loss of control' [the crucial phase] is the beginning of the 'disease process' of alcohol addiction which is superimposed over the excessive symptomatic drinking. Progressively, this disease process undermines the morale and the physical resistance

of the addict" (1952:682). Jellinek concluded that "only an originally psychopathic personality or a person who has later in life undergone a psychopathological process would expose himself to that risk" (1952:682).

Jellinek left the Yale Section in the late 1940s to establish an alcohol studies institute at Texas Christian University based on the Yale model. When this effort failed, he worked abroad as Consultant of Alcoholism for the World Health Organization. But Jellinek's reputation for having built "a legitimate field of scientific study" on alcoholism preceded him (Page 1997:1627). In 1957, he returned to the United States to write a synopsis of the alcohol studies field funded by the Christopher D. Smithers Foundation. The Smithers Foundation financially supported the alcoholism movement, donating at least $12 million to its various elements. Its founder, R. Brinkley Smithers, was a recovering alcoholic who Jellinek "treated" and who personally contributed over $25 million to the movement (White 1998).

Jellinek's synopsis of the alcoholism field is still influential today. Entitled *The Disease Concept of Alcoholism*, Jellinek defined alcohol addiction as "any use of alcoholic beverages that causes any damage to the individual or society or both" (1960:35). Jellinek argued that the value of this definition lies in its "uselessness, … for it forces us to single out species of alcoholism … and to speak of them in stringent terms. We must be particularly definite about those forms which we wish to examine as possibly constituting illnesses" (1960:35-36).

Jellinek identified five species of alcoholism with Greek letters. *Alpha alcoholism* indicated a psychological dependence on alcohol that relieved physical or

emotional pain. *Beta alcoholism* referred to heavy social drinking that caused physical damage but not biological or psychological dependence. In *Delta alcoholism* "there is no ability to 'go on the water wagon' for even a day or two without the manifestation of withdrawal symptoms" (Jellinek 1960:38). Jellinek defined *Epsilon alcoholism* as "periodic alcoholism" but offered no description due to its rarity.

Jellinek's best known species is *Gamma alcoholism*, characterized by "increased tissue tolerance to alcohol," "adaptive cell metabolism," and withdrawal. A loss of control over drinking is inevitable (see Jellinek 1960:37). Jellinek stated that Gamma alcoholism is predominant in the United States and is "what members of Alcoholics Anonymous recognize as alcoholism to the exclusion of all other species" (1960:38). Gamma alcoholism delighted AA alcoholics who wanted their condition medicalized and who recognized the educational and fundraising prowess of Jellinek's work (Page 1997). "The classic American disease pattern now was baptized as *gamma alcoholism*" (Fingarette 1988:20).

The Public Relations Campaign of Marty Mann

Alcoholics Anonymous and E .M. Jellinek made important contributions to the concept of alcoholism as an illness. But Marty Mann, Harry M. Tiebout's former patient, popularized chronic drunkenness as a medical problem.

After leaving Blythewood Sanitarium, Mann worked in New York City as a radio scriptwriter for the American Society of Composers, Authors, and Publishers

where she learned about Dorothea Dix's nineteenth century campaign to improve treatment for the mentally ill (Brown and Brown 2001; White 1998). Convinced that a crusade to destigmatize alcoholism would be equally effective, Mann devised a three-part plan to promote alcohol addiction as a medical problem and not a moral failing. First, she proposed a series of lectures for doctors, nurses, and clergy in the alcoholism field. These respected community leaders could then publicize the medical "facts" about alcoholism. Second, Mann wanted to open alcoholism information centers in cities across the country to advertise alcoholism as an illness. Third, Mann planned to persuade hospitals to admit alcoholics for treatment to portray habitual drunkenness as a medical condition (Johnson 1973). "Convinced of the validity of the A.A. ideology, [Mann] envisioned a society in which these ideas would be common knowledge and accepted as scientific facts" (Johnson 1973:266).

Mann discussed her plan with Bill Wilson who cautioned that it needed support from the medical community if the public was to embrace it. Mann contacted the Research Council on Problems of Alcohol. Dr. Harry H. Moore, the Research Council's director, liked Mann's proposal so much that he offered her a job speaking to medical groups. Mann declined because she lacked scientific credentials. Ultimately, a physician interested in alcoholism named Ruth Fox, Mann's close friend, took the plan to E. M. Jellinek at the Yale Section of Alcohol Studies (Johnson 1973).

Jellinek was in his first year as director of the Yale Section when Fox and Mann approached him. He took to Mann's proposal immediately and persuaded his

colleagues that Mann was an ideal candidate to popularize the Yale Section's science on alcohol. In 1944, funded by Yale, Mann moved to New Haven, Connecticut to form the National Committee for Education on Alcoholism (NCEA). The *Quarterly Journal of Studies on Alcohol* listed NCEA's objectives:

> The Committee aims to gain acceptance by the general public of these five cardinal points: 1. Alcoholism is a disease. 2. The alcoholic, therefore, is a sick person. 3. The alcoholic can be helped. 4. The alcoholic is worth helping. 5. Alcoholism in our No. 4 public health problem, and *our* public responsibility (Mann 1944:357).

"[T]he total effort of the National Committee," Mann wrote in the same report, "will be directed toward bringing the facts of alcoholism before the public and spreading knowledge about it by word of mouth and through the printed page, and fostering the creation of clinics and other facilities for the rehabilitation of tens of thousands of alcoholics" (1944:358).

In the Fall of 1944, Mann moved NCEA's headquarters to the New York Academy of Medicine in New York City (Brown and Brown 2001). As a former journalist, Mann used her media contacts to publicize NCEA and promote alcoholism as a treatable illness. After a 1944 press conference with Jellinek, for example, a story about NCEA appeared in *Time Magazine* (Johnson 1973). By early 1945, Mann made almost 50 speaking appearances in 13 states. Local NCEA affiliates cropped up in cities across the country (Johnson 1973). Staffed by recovered AA alcoholics who attended the Yale Summer School of Alcohol Studies, an educational initiative

sponsored by the Yale Section (White 1998), these affiliates operated treatment clinics and extended care facilities based on AA's Twelve Step program. By 1946, Mann had made over 100 speeches in 45 cities and helped establish 14 NCEA affiliates (Johnson 1973).

Despite these successes, NCEA's relationship with the Yale Section deteriorated as Mann's organization struggled financially. "From [Mann's] point of view, the only reason for establishing clinics or conducting research on the effects of alcohol on the human system was to lend credibility to the medical model of drunkenness" (Johnson 1973:290). But this perspective put NCEA at odds with Yale. The university was committed to research and education, not advertising and marketing. Moreover, NCEA affiliate programs took financing that the Yale Section expected in return for its sponsorship. Yale's insistence that Mann staff an office in New Haven without sufficient funds and uncertainty among financiers as to which organization their money supported added to the problems. Statements from the Yale Section that questioned the medical model of alcoholism sealed the deal (see Bacon [1945] 1972; Bales 1946).[7] On December 31, 1949, NCEA and the Yale Section separated (see Brown and Brown 2001; Johnson 1973). Marty Mann's impact on the medical model of addiction—an "unguarded secret" in her words (1944:354)—had already taken root.

Alcoholism: An Official Medical Problem

In 1956, the American Medical Association (AMA) House of Delegates, the policy arm of the AMA, adopted a resolution on hospitalizing alcoholics that called

alcohol addiction an "illness." Although the reference was subtle, alcoholism became an official medical problem:

> [T]here should be adequate facilities available as part of a hospital program for care of alcoholics. Since the house officer in a hospital will eventually come in contact with this type of patient in practice, his training in treating this *illness* [emphasis added] should come while he is a resident officer. Hospital staffs should be urged to accept these patients for treatment and cooperate in this program (American Medical Association 1956:32-33).

Selden Bacon and Marvin Block crafted this resolution (Johnson 1973). Bacon, a sociologist, headed the Yale Section of Alcohol Studies after Jellinek's departure. Block, a physician who did most of the lobbying for the resolution, became interested in alcoholism after a colleague and recovering alcoholic "decided to carry his ideas up through the ranks of the organized medical profession to see if he could not get concerted national action toward increasing interest in this problem among doctors" (Block 1959:475). NCEA, renamed the National Council on Alcoholism in 1954, also lobbied strongly for the resolution, thereby achieving one of its core objectives (White 1998). Jellinek referred to the resolution as a "decisive factor" (1960:10) in the ultimate triumph of the new understanding of alcoholism.

The medicalization of alcoholism succeeded because of the public's renewed faith in science to solve social problems. "After the failure of legislative controls, science offered a fresh approach—unbiased, based on empirical truths—to an old problem which had heretofore defied public solutions" (Page 1988:1096). Drs.

Silkworth and Tiebout, and later E. M. Jellinek and the Yale Section of Alcohol Studies, embodied this half of the alcoholism enterprise. With alcohol addiction atop the "mantle of scientific authority" (Page 1997:1627), Alcoholics Anonymous and the National Council on Alcoholism simplified chronic drinking conceptually and marketed their ideology and philosophy of care to the lay public and medical professionals (White 1998). As Conrad and Schneider explain, "the allergy metaphor identifie[d] alcoholism as a bona fide medical or 'disease' condition. This in effect legitimize[d] the medical definition of such drinkers as 'sick'" (1980:89).

Freidson notes that "the medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively" (1970:251). In 1956, organized medicine claimed jurisdiction over alcoholism even though the medical profession was indifferent to addiction treatment. Physicians interested in substance abuse like Marvin Block, however, believed that the AMA's resolution sent an important message to the medical community. "[T]he organized profession itself can be of very little help unless the individual physician recognizes his responsibility in his own community to the patient suffering from alcoholism. One thing is clear. He can no longer avoid this issue" (Block 1959:480).

Table 1

The Twelve Steps of Alcoholics Anonymous*

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.

*Alcoholics Anonymous World Services, Inc. (2001: 59-60). The Twelve Steps are reprinted with permission of Alcoholics Anonymous World Services, Inc. ("AAWS"). Permission to reprint the Twelve Steps does not mean that AAWS has reviewed or approved the contents of this publication, or that AAWS necessarily agrees with the views expressed herein. A.A. is a program of recovery from alcoholism only—use of the Twelve Steps in connection with programs and activities which are patterned after A.A., but which address other problems, or in any other non-A.A. context, does not imply otherwise.

Notes

[1] A comprehensive review of how Bill Wilson and Dr. Robert Smith founded Alcoholics Anonymous is beyond the scope of this chapter. For three excellent treatments of this history, see Alcoholics Anonymous World Services, Inc., *Alcoholics Anonymous Comes of Age: A Brief History of A.A.* ([1957] 1971); Kurtz, *Not-God: A History of Alcoholics Anonymous* (1979); Pittman, *AA: The Way it Began* (1988).

[2] Brown and Brown, *A Biography of Mrs. Marty Mann* (2001), accurately note that the phrase "we cannot live in anger" does not appear in the Big Book. The words Marty Mann was probably referring to are: "if we were to live, we had to be free of anger." See Alcoholics Anonymous World Services, Inc., *Alcoholics Anonymous: The Story of How Many Thousands of Men and Women Have Recovered from Alcoholism* (2001), 66.

[3] Today's addiction medicine physicians and addiction psychiatrists agree with Harry M. Tiebout's assessments of psychiatric treatment for addiction. "If you go back in the last century from 1900 to about 1965," said one addiction medicine physician, "psychiatrists were the primary people who treated chemical dependency. Certainly the internists and primary care doctors didn't want to treat [it]…. [But] as to whether they did any good … the answer is very clearly no. Psychoanalysis … [was] not the best tool to use in chemically dependent [patients]" (AM-4). An addiction psychiatrist explained why. "In the [19]30s, [19]40s, [and] [19]50s, many psychiatrists saw [addicts] … [as having] an underlying psychiatric disorder. Through psychoanalysis … [psychiatrists] could … figure out what the underlying disorder was that expressed itself as drug dependency. Many, many patients saw [psychiatrists] and would lie on the couch [but] very little was done related to their dependency" (AP-9).

[4] Bowman's decision to raise money for Jolliffe's research signaled the Research Council's exclusive focus on alcoholism as opposed to general matters related to alcohol. Roizen calls this decision "Bowman's Compromise." See Roizen, "The American Discovery of Alcoholism, 1933-1939" (1991). Also see Research Council on Problems of Alcohol, "Activities of the Research Council on Problems of Alcohol" (1940b); White, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (1998).

[5] E. M. Jellinek's academic credentials remain controversial. Jellinek apparently received several graduate degrees and even a medical degree from European and Central American universities. But whether these degrees were honorary, or conferred at all, is uncertain. See Page, "E. M. Jellinek and the Evolution of Alcohol Studies: A Critical Essay" (1997).

[6] The research sample from which E. M. Jellinek drew his results consisted of 98 male alcoholics. Jellinek excluded *AA Grapevine* surveys that women completed, 15 in total, claiming that there was not enough data to analyze and that the women's responses differed too greatly from the men's responses. Jellinek discarded an additional 17 surveys that were improperly completed and one survey on which 28 members of one AA group combined and averaged their answers. In total, the survey response rate was 10 percent in light of the *AA Grapevine's* 1,600 copy circulation. See Jellinek, "Phases in the Drinking History of Alcoholics" (1946).

[7] Sociologist Selden Bacon attributed alcohol addiction to an increasingly specialized and complex society. "The advantages of a complex society are manifest," Bacon wrote. "But there is a price to pay…. It can be roughly labeled as emotional insecurity for the individual. Since alcohol can reduce the impact, can allow escape from the tensions, fears, sensitivities, feelings of frustration, which constitute this insecurity, its role will be more highly valued." See Bacon, "Alcohol and Complex Society" ([1945] 1972), 192.

CHAPTER TWO

THE FOUNDATION OF ADDICTION MEDICINE

Imagine such a disease.

—Dr. Ruth Fox (1970:xiii)

In the late 1930s, Freudian psychoanalysis, which probed unconscious thoughts and childhood experiences, ruled psychiatry and addiction treatment (Shorter 1997). "To bring about the character revision necessary to relieve alcohol addiction," Karl Menninger wrote, "requires psychological 'surgery,' i.e., psychoanalysis" (1938:160). Not all psychiatrists agreed, however. William D. Silkworth, the Physician-in-Chief of Towns Hospital, said that alcoholism was a physical illness—an "allergic state" (Silkworth 1937). Harry M. Tiebout of Blythewood Sanitarium argued that the consequences of alcohol addiction should eclipse its causes (Tiebout ([1951] 1999).

In 1956, the American Medical Association called alcoholism an illness. Rank-and-file doctors were not obligated to treat addicts as a result, but the medicalization of alcohol addiction prompted some doctors to do just that. Starting in the 1950s, physicians in New York and California laid the foundation for "addiction medicine." These doctors believed that they had a professional responsibility to treat drug abuse and that addiction medicine should be a mainstream medical discipline in the tradition that the alcoholism movement started.[1]

The American Medical Society on Alcoholism

Ruth Fox was a New York City internist who later practiced psychiatry (Lewis 1996). Her husband was McAlister Coleman, a prominent socialist and three-time candidate for Congress who was also an alcoholic (Brown and Brown 2001; Johnson 1973). In 1941, after reading Jack Alexander's story about Alcoholics Anonymous in *The Saturday Evening Post*, Fox attended a meeting to see if the fellowship could help her husband. Marty Mann was new to Alcoholics Anonymous and spoke that evening. Fox and Mann became close friends and colleagues as they tried in vain to keep Coleman sober (Brown and Brown 2001).

In 1944, Fox took Mann's idea for the National Council on Alcoholism (NCA) to E. M. Jellinek at the Yale Section of Alcohol Studies. Fox knew Jellinek through her husband. "She offered to write a letter of introduction to Jellinek to accompany Marty's threefold plan. Because she was a physician, Ruth's recommendations would carry weight" (Brown and Brown 2001:159). In 1951, Mann turned to Fox once again after NCA and the Yale Section separated. Mann wanted to establish a medical division of NCA called the New York City Medical Committee on Alcoholism. Headed by Fox and controlled by Mann, the committee met several times, but its members ultimately formed an autonomous organization of physicians called the New York City Medical Society on Alcoholism.

In 1954, the New York Society held its first meeting at the New York Academy of Medicine, the same institution that headquartered NCA. About 15 doctors interested in alcoholism treatment attended, including Stanley Gitlow,

LeClair Bissell, Percy Ryberg, Harold Lovell, Howard Zucker, and Maxwell Weisman. Ruth Fox became the organization's first president. She and her colleagues believed that alcoholics deserved medical attention. "[Fox's] pioneering work was to accept alcoholics as private patients, treat them through and after the withdrawal from dependence on alcohol, and then subject her experience to study" (Bromley 1992:1531).

The New York Society disseminated medical knowledge about alcoholism and was active in public policy. Alongside NCA, one of the organization's earliest and most important initiatives was to see that hospitals accepted alcoholics for treatment. "They had a little influence," said one physician familiar with the New York Society, "because the AMA … declared that alcoholism was a disease in 1956" (AM/AP-19).[1] [2] The New York Society's influence came from its most prominent members, including Howard W. Haggard of the Yale Section of Alcohol Studies and Marvin Block, chief architect of the AMA's landmark "illness" resolution.

Marty Mann also kept a close watch over the New York Society. High-ranking members of NCA served as officers in the New York Society and NCA funded many of the New York Society's research and educational initiatives. The

[1] The following codes are used throughout this manuscript to signify the medical affiliation of interview respondents: **AM** = addiction medicine physician; **AMO** = former addiction medicine official; **AP** = addiction psychiatrist; **APO** = former addiction psychiatry official; **AM/AP** = physician certified in addiction medicine and addiction psychiatry**; AM/P** = physician certified in addiction medicine and general psychiatry; **ABPNO** = American Board of Psychiatry and Neurology official. The number adjacent to each interview respondent indicates the order in which he or she was interviewed. Given the politically-charged topics this research covers, I have tried to preserve respondent confidentiality as best as possible so that the interview data are not overshadowed by their source. When medical professionals are mentioned by name, it is because other interview respondents talked about their significance to addiction medicine and addiction psychiatry or in reference to their scholarly work. See Appendix A for a complete discussion of methods.

relationship was reciprocal. In 1958, Fox became the medical director of NCA. In April that year, Bill Wilson addressed the New York Society to praise the organization's work. "When our combined understanding and knowledge have been fully massed and applied," Wilson stated, "we of A.A. know that we shall find our friends of medicine in the very front rank—just where so many of you are already standing today" (Bill W. [1958] N.d.:21-22).

In 1961, Fox resigned as president of the New York Society. By then she had solidified her stature, and that of the New York Society, in the field of alcoholism. Fox advocated a comprehensive approach to treating alcohol addiction that included disulfiram, or Antabuse. When mixed with alcohol, this medication makes drinkers physically ill and "free[s] the mind" from the uncontrollable urge to drink (Fox 1965b:A-110). Fox was partial, however, to Twelve-Step treatment, perhaps influenced by her husband and Marty Mann. "[I]f I had to be limited to one form of therapy," Fox wrote, "I would, of course, choose Alcoholics Anonymous. This fellowship has alerted us to prevalence of alcoholism, has taught us how to treat it, and most important of all, it has added the element of hope without which medicine would be pretty powerless" (1960).[3]

Addiction expert Dr. Marc Galanter of New York University provides additional insight into Fox's commitment to the Twelve Step program of recovery:

> [The New York Society] was established in 1954, when there were few approaches to the treatment of addiction available to the physician other than Alcoholics Anonymous. At its inception many [New York Society] physician

> members were recovering from alcoholism through AA spirituality and had decided to dedicate their careers to others who suffered as they had. The other members had come to treat alcoholic patients based on the nature of their clinical practices, but they also relied on AA's spiritual commitment to move their patients toward recovery. In those days [the New York Society's] meetings were imbued with the twelfth of the AA Steps, a commitment 'to carry this message to alcoholics and practice these principles [the Twelve Steps] in all our affairs.' Members sustained a remarkable degree of fidelity to the society because of the mutuality inherent in this approach (2005:50).

The *Physician's Alcohol Newsletter* brought more attention to the New York Society. First published in 1965 by Dr. Frank Seixas, a member of the New York Society who served as medical director of NCA after Fox, this educational bulletin enjoyed a national readership and drew praise from key health care institutions such as the United States Department of Health, Education, and Welfare and the New York State Department of Mental Hygiene. The newsletter was paid for by R. Brinkley Smithers, the recovered alcoholic and financier of the alcoholism movement who helped fund the New York Society and who, as NCA treasurer, subsidized Fox's salary as medical director (White 1998). By the end of the 1960s, circulation of the *Physician's Alcohol Newsletter* reached upwards of 17,000 copies.

In 1967, the year the American Medical Association called alcoholism a "complex disease" that physicians should treat (see American Medical Association 1967), the New York Society changed its name to the American Medical Society on

Alcoholism (AMSA). With interest in the organization beyond New York, AMSA hosted medical conferences and planned to set up medical affiliates across the nation to publicize itself as a new national society.

In 1969, Fox stepped down as the medical director of NCA. Problems arose after she was elected president of AMSA the same year. First came rumblings from AMSA physicians in California about the organization's reluctance to include drugs besides alcohol on its national agenda. In a 1971 message to Congress, President Nixon warned that an entire generation might be lost to "the tide of drug abuse which has swept America in the last decade" (Nixon, as cited in Zimring and Hawkins 1992:46). The medical and social implications of Nixon's speech prompted some physicians to argue that all addictions required medical care, not just alcoholism.

Fiscal problems were equally burdensome. In fact, in 1973 financial difficulties forced AMSA to become the medical division of NCA, temporarily assuaging the Californians' concerns about AMSA's national agenda. Leaders of AMSA such as Stanley Gitlow and Marvin Block feared losing medical credibility by merging with NCA's lay activists. Members of NCA expressed concern that some AMSA physicians, particularly the psychiatrists, dismissed the disease concept of alcoholism. The merger went forward nonetheless. AMSA's survival was at stake, but so too was Marty Mann's opportunity to claim as she did with the Yale Section that affiliated medical "experts" endorsed her mission to destigmatize alcoholism.

In 1976, AMSA and NCA published a joint definition of alcoholism to underscore their new alliance. "Alcoholism is a chronic, progressive, and potentially

fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both—all the direct or indirect consequences of the alcohol ingested" (1976:764). AMSA operated under NCA's control for 10 years.

The California Society for the Treatment of Alcoholism and Other Drug Dependencies

In 1969, Dr. Jess W. Bromley was Chief of Staff at San Leandro Memorial Hospital in San Leandro, California and a member of the California Medical Association's (CMA) Committee on Dangerous Drugs. Bromley started a drug treatment program in San Leandro in response to an increase in suburban drug use and overdoses, but noticed that few physicians treated addicts (Heilig 1993). "I concluded," Bromley said, "what we really needed was to get organized, and then to work towards establishing a new specialty" (Bromley, as cited in Heilig 1993:1).

Other doctors in California agreed. Jack Gordon, an internist and former chair of the CMA's Committee on Alcoholism, recalled that physicians in California have treated alcoholism since the 1950s and 1960s. "[T]he basic idea," Gordon said, "was simply to treat alcoholics as human beings" (Gordon, as cited in Heilig 1993:2). George Lundberg, a former editor of the *Journal of the American Medical Association*, considered recreational drug use a problem that most physicians ignored or did not recognize (Heilig 1993). The status quo needs to change, Lundberg argued. "We started putting on programs on substance abuse for parents, employers, teachers and so on, and got a big crowd from all those groups. But when we put on programs for physicians, nobody would come" (Lundberg, as cited in Heilig 1993:2)!

Pediatrician Arthur Bolter thought that California doctors in the addictions field needed more professional support. "There was no place physicians could identify themselves as being interested in treating addicts," Bolter said. "For years, the stereotype was that 'drunks were treating drunks,' with questionable means and outcomes. We thought that people who were treating what others saw as a 'loathsome' problem should get some respect" (Bolter, as cited in Heilig 1993:2)!

Indeed, a small but growing group of physicians in California wanted the medical treatment of addiction to be part of mainstream medicine—"remedicalized" as Bromley said (see Bromley 1992). However, California Health and Safety Code prohibited doctors from treating addicts outside of a city or county jail or hospital, a state prison or hospital, or a facility approved by the State Department of Mental Health or licensed by the State Department of Alcohol and Drug Programs. This statute was similar to the Harrison Narcotic Act of 1914 which resulted in the imprisonment of physicians who treated opiate addicts (Heilig 1993).[4] Since the early 1900s, in fact, California physicians in the addictions have been closely monitored. In 1909, for example, "good faith" addiction treatment according to the California State Board of Pharmacy meant slow withdrawal, not maintenance of dependence (Baumohl 2004:226). Bromley was not surprised, then, when two doctors were arrested for treating heroin addicts at a local community hospital (Heilig 1993).

This incident prompted Bromley to try to change the law. In 1971, with help from the CMA and grassroots support from Dr. David E. Smith and the Haight

Ashbury Free Clinics, Bromley and his colleagues authored and successfully lobbied for a bill to "change the restrictive state drug law in order to bring it into conformance with reasonable clinical practice" (Bromley, in Heilig 1993:2). The California Legislature revised the Health and Safety Code to read as follows:

> [A] licensed physician and surgeon may treat an addict for addiction in any office or medical facility which, in the professional judgment of such physician and surgeon, is medically proper for the rehabilitation and treatment of such addict. Such licensed physician and surgeon may administer to an addict, under his direct care, those medications and therapeutic agents which, in the judgment of such physician and surgeon, are medically necessary, provided that nothing in this section shall authorize the administration of any narcotic drug (California Health and Safety Code Section 11215-11222 N.d.).

The revised code convinced the CMA's alcoholism and drug committees to unite for added political strength. The new Committee on Alcoholism and Other Drug Dependencies then requested authorization from the CMA to form a separate medical society (Heilig 1993). According to Bromley, "there were some visionary people there [at the CMA] at the time who saw this as an important field needing more medical involvement" (Bromley, as cited in Heilig 1993:3). Gail B. Jara was one of those people. A seasoned CMA insider, Jara used her considerable connections in organized medicine in California to help form the new medical society. She also honored Bromley's ultimate goal:

> The contribution [Jara] made was to … understand [Bromley's] vision…. He really knew what he wanted. He knew what needed to be accomplished in order to have what he kept calling from the very beginning the '[re]medicalization' of the treatment of addiction. He wanted it to be within the mainstream of medical care; 'mainstreaming' was his 'by' word. [Jara] could hear it, understand it, make it happen. [She] was the implementing partner [and] he was the visionary partner (AMO-1).

In 1973, Bromley and Jara founded the California Society for the Treatment of Alcoholism and Other Drug Dependencies—the California Society. Jara was named Executive Director and Dr. Charles Becker of the University of California, San Francisco became the organization's first president (Heilig 1993). The California Society addressed standards and reimbursement for addiction treatment, chemically-dependent physicians, medical education on substance abuse, and certification and credentialing for doctors in the field (Heilig 1993). As one original member of the California Society said, "I'm not an alcoholic or drug addict, and early on some people wouldn't listen to me because I wasn't, while others wouldn't because they thought I was!... So the development of recognized expertise was reason enough to start this association" (Becker, in Heilig 1993:5). Doctors in the academic medical community also gave their support "to add to the recognition," one California Society member conceded, "that we weren't a bunch of quacks" (Gordon, in Heilig 1993:3).

AMSA and the Los Angeles affiliate of NCA provided additional input. However, while Bromley acknowledged that "the beginnings of a new focus or

remedicalization [of addiction] might be placed in the living room of Ruth Fox" (1992:1531), the relationship between the California Society, AMSA, and the National Council on Alcoholism was strained (Heilig 1993). "The Californians were focused on establishing a role in the mainstream of both organized medicine and academic medicine for the physicians who treated all drug dependence. They did not endorse [as AMSA did] the separation between alcohol and other drugs" (Heilig 1993:3).

Nevertheless, the development of AMSA and the California Society marked a turning point. In less than 20 years, 1954 to 1973, physicians who treated and studied addiction no longer had to work in isolation—"an idea whose time had come" commented one observer (Heilig 1993:1). Although most doctors ignored addiction despite statements from the American Medical Association that addicts required medical attention, physicians in AMSA and the California Society drew support from a professional network of peers who believed that "addiction medicine" was their responsibility and deserved mainstream medical status.

Notes

[1] Some historical information in Chapters Two through Four derives from a private manuscript about the evolution of addiction medicine.

[2] The American Medical Association resolution that called alcoholism an “illness” in 1956 is often credited by medical professionals and addiction experts as describing alcoholism as a “disease.” Marvin Block, who crafted the resolution, also used these terms interchangeably: “the largest medical organization in the world [has] now recognized alcoholism as an illness within the purview of medical practice and properly classified as a *disease* [emphasis added] which warrants admission to general hospitals for those people suffering from it.” See Block, "Alcoholism and the Medical Profession" (1959), 477.

[3] Ruth Fox called alcohol addiction a “psychophysiocultural” disease. See Fox, "Alcoholism in 1966" (1966), 338. More specifically, Fox believed that alcohol addiction was a primary illness that caused psychological problems, not the other way around. “Alcoholism causes a regression in the patient to infantile states. Psychologic characteristics … [show] an inner battle between passivity and aggression; low frustration tolerance; inability to endure anxiety or tension; feelings of isolation; devalued self-esteem, with sometimes overcompensation; undue sensitiveness; impulsive, repetitive acting out of conflicts; masochistic, self-punitive behavior and extreme narcissism or exhibitionism; strong sense of guilt; hostility, either overt or covert; strong dependent needs; marked rebellion; repressed grandiose ambitions with little ability to persevere; and always sexual maladjustment. Many of these symptoms disappear when the alcoholic becomes consistently abstinent.” See Fox, "Psychiatric Aspects of Alcoholism" (1965a), 416.

[4] The Harrison Narcotic Act of 1914 was America’s first federal law on narcotic drug use. Congress originally passed the law as a tax and registration requirement for opium and cocaine manufacturers. However, the United States Supreme Court, influenced by alcohol and drug prohibitionists, ruled that the Harrison Narcotic Act criminalized recreational opiate and cocaine use as well as the medical maintenance of opiate addicts under a physician’s care. For more information, see Musto, *The American Disease: Origins of Narcotic Control* ([1973] 1999); Reinarman and Levine, "Punitive Prohibition in America" (1997b).

CHAPTER THREE

THE IMPACT OF IMPAIRED PHYSICIANS

Physician, cure yourself.

—Luke 4:23

As AMSA and the California Society continued to develop addiction medicine in the 1970s, the medical profession turned its attention to drug abuse among physicians. Several members of AMSA and the California Society were themselves former addicts, but the American Medical Association framed addiction among physicians as a profession-wide, psychiatric problem. This led to the impaired physician movement, the rise of "addictionology," and a unified field of addiction medicine. Physicians who treated substance abuse also received mainstream medical status.

The Sick Physician

In 1973, the American Medical Association Council on Mental Health issued a report on psychiatric disorders, including addiction, entitled "The Sick Physician." This report, organized medicine's first formal response to drug abuse among medical professionals, "built upon 20 years of pioneering efforts by psychiatrists, many working from the perspective of physician suicide, who called attention to the toll that end-stage impairment exacted from medicine, said to equal one medical class yearly" (Sargent 1985:295). The Sick Physician report quoted Modlin and Montes (1964)

who found that physicians comprised approximately 15 percent of all drug addicts in the United States. Moreover, doctors were 30 to 100 times more likely to become addicts than members of the general population. Modlin and Montes attributed addiction to "a symptom of moderately severe progressive personality disorganization" (1964:362). Substance-abusing physicians had stern and withdrawn fathers and depressed and overprotective mothers. Troubled marriages and job dissatisfaction compounded these childhood difficulties. Easy access to narcotic drugs compelled doctors to seek an "episodic tension-free, frustration-free nirvana worth to them whatever price they have to pay" (Modlin and Montes 1964:363).

In 1970, Vaillant and colleagues published a 20 year prospective study on addicted physicians and discovered that doctors abused tranquilizers, sedatives, and stimulants more than similarly matched general population controls. Vaillant blamed excessive drug use on a physician's tendency to self-prescribe and self-medicate: "after giving of himself to others, the physician may feel more than ordinarily entitled to 'prescribe' drugs secretly for himself when he gets home" (1970:369). Dependency, passivity, pessimism, and self-doubt increased a doctor's vulnerability to drug abuse. "[I]t is when the physician from a barren childhood becomes overly burdened by the demands of his dependent patients that trouble arises," Vaillant and his associates concluded. "He, not the literally overworked doctor, resorts to drugs to alleviate fatigue" (1972:375). Lastly, one commentator stated:

> It is well known that the incidence of opiate and opioid addiction among physicians is some 20 to 30 times higher than in the general population. The

> malevolent combination of pressures from upward-striving and easy availability of opiates no doubt is behind this tragedy. The re-enforcing properties of intravenous opiates are extraordinary, and once an overworked, conscientious, perhaps somewhat depressed, middle-aged man has supped at that table, it is very difficult for him to turn away without the benevolent help of his own profession (Anonymous 1976:221).

These and similar findings brought the issue of addiction among physicians to the forefront of American medicine. If addicted doctors did not seek treatment and temporarily or permanently suspend their clinical activities, their colleagues were obligated to intervene and, if necessary, report them to medical supervisory staff, state medical societies, and state licensing boards (American Medical Association Council on Mental Health 1973).[1]

The Impaired Physician Movement

The Sick Physician report revealed what most doctors already knew about some of their associates. It also stimulated the "impaired physician movement." Led by Emanuel M. Steindler, director of mental health at the American Medical Association, LeClair Bissell, one of AMSA's founding members and director of the Smithers Alcoholism Treatment Center,[2] and Luke K. Reed of International Doctors in Alcoholics Anonymous,[3] the impaired physician movement was a network of doctors, mostly former addicts, that supported physicians with drug problems and lobbied state medical societies to establish treatment and advocacy programs on their behalf (Steindler 1984; Talbott 1988). According to G. Douglas Talbott, one of the

movement's most active members, "a medical society's impaired physicians program can assure the state's citizens that physicians will not practice medicine until they are in recovery (and thus provide good quality control of medicine in that state)" (1988:216). Steindler "believe[d] that the physician will, as a result of what we do, become more attentive to his or her own personal health and recreational needs and will view them in the context of the health and well-being of spouses and children" (1984:743).

Impaired physicians, like other addicts, also received poor drug treatment from psychiatrists. "The impaired physician movement grew as a necessary reaction to the conflicts inherent in the healing profession's attempt to heal its own" (Sargent 1985:295). Rogers J. Smith and Howard Rome, the psychiatrists who authored The Sick Physician report (Sargent 1985), wrote that "as with the lay patient, the drug-dependent or alcoholic physician must recognize that he has a mental disorder and communicate with a competent source of assistance" (American Medical Association Council on Mental Health 1973:687).

At the time, however, psychoanalysis still dominated drug treatment, even for physicians, despite the medical community's recognition of addiction as a disease. A 1976 study by LeClair Bissell and Robert W. Jones, for instance, found that psychiatrists treated most alcoholic physicians and classified alcohol addiction as a symptom of a mental problem. "Since it is virtually impossible to arrive at a reasonable treatment plan for a disease whose existence is not acknowledged," Bissell

and Jones wrote, “this behavior had frequently resulted in dangerous delays in obtaining appropriate treatment” (1976:1144).

Addiction experts in this study, some recovering from alcoholism and drug abuse, echoed this finding. “For years nobody would have anything to do with the disease,” one addiction medicine physician said, “and sort of by practice and tradition the psychiatrists were the only ones who looked at addiction. You know the old saying—scratch any alcoholic and you’ll find a schizophrenic, you’ll find a manic depressive. That was an attitudinal thing that went along for years” (AM-11). An addiction psychiatrist identified the genesis of this sentiment. “You [had] in the [19]60s and [19]70s psychiatrists [with] no training in [the] addictions handing out meds—no sophistication—and really making [addiction] problematic for people who were trying to recover. That was 35 or 40 years ago. That’s long gone and yet the stigma remains” (AP-14). Another doctor said that “psychiatric treatment for the addictions in the [19]50s, [19]60s, and [19]70s [was] an unmitigated disaster accompanied by a great deal of arrogance” (AM-5). A colleague concurred: “prior to the 1980s, most addicts who saw psychiatrists were damaged by that experience” (AM/P-18).

In 1975, the St. Francis Drake Hotel in San Francisco, California hosted the first national conference on impaired physicians. Over 100 participants debated whether to call addicted doctors “disabled” or “impaired” (Sargent 1985; Talbott 1988). “The big argument was … are we going to call [them] impaired physicians or sick physicians or disabled physicians,” said one doctor who attended the meeting.

"Impaired stuck around but it was never popular" (AM/AP-19). Even so, turnout quadrupled by the fifth national conference and "the sixth national conference … was the most enthusiastic meeting yet, clearly demonstrating that [the] AMA's investment in education on physician impairment is paying off" (Sargent 1985:295). Emanuel M. Steindler played an important role (Sargent 1985):

> We need to be assertive and forthright in our determination to overcome the stigma that still, too often attaches to those who have had alcoholism, drug dependence, or mental illness. This becomes especially crucial when physicians attempt to pick up the pieces of their lives, after successfully undergoing treatment and rehabilitation, or when medical students who have had these problems and drop out of school try to resume their training (Steindler 1984:743).

Physicians recovering from addiction did return to medicine. In fact, some doctors "[were] of the mind that every physician who fell to alcohol and drug abuse needed to become an addiction [medicine specialist]" (AM-10). G. Douglas Talbott of the impaired physician movement agreed. Talbott was instrumental to the impact that physicians in recovery had on addiction medicine.

The Dawn of Addictionology

In 1953, despite frequent bouts of heavy drunkenness, G. Douglas Talbott finished his medical residency in cardiology and internal medicine at the University of California, San Francisco. Having damaged his health, family life, and

professional reputation just as his career was starting, Talbott was sent to several psychiatric hospitals for treatment. Finally he was committed to Dayton State Hospital in Ohio where he was housed with the criminally insane and endured physical and emotional assaults. But as Talbott explained years later, something else happened there:

> I will never forget lying there bleeding, in severe pain, and even suffering through the humiliation of being urinated on. I kept thinking, God, where are you? Lying on the floor that night, I clearly remember making a vow to myself that if I ever got out of this place alive, I would dedicate my life to helping doctors and other health care professionals in this situation. I vowed I would find a way to help suffering doctors like myself and dreamed of one day creating a place where healers could be healed (1998:xvii).

Talbott experienced a "spiritual awakening" that was conspicuously similar to the "hot flash" reported by Alcoholics Anonymous co-founder Bill Wilson and "the light" seen by Marty Mann, founder of the National Council on Alcoholism. Talbott attributed his sobriety to his family and a Catholic priest who renewed his spiritual faith and convinced him to join Alcoholics Anonymous. This priest also supported Talbott's decision to leave his medical specialties of cardiology and internal medicine in order to learn more about alcoholism at the Rutgers Center of Alcohol Studies (Talbott 1998).[4]

By 1971, Talbott had helped to organize an impaired physician program for the Maryland State Medical Society. "This was the very beginning of the impaired

physicians movement," Talbott later wrote (1998:xviii). When funding for this program ran out in the mid-1970s, Talbott moved to Georgia where he started the Disabled Doctors' Plan. Based on the Twelve Step program of Alcoholics Anonymous, the Disabled Doctors' Plan featured one month of inpatient care followed by another month of outpatient work and two months of addiction treatment apprenticeship under former disabled physicians (Sargent 1985; Talbott, Richardson, and Atkins 1977). A program at the Talbott Recovery Campus in Atlanta, Georgia also stressed the spiritual development of patients during one month of inpatient rehabilitation, one month of outpatient care, two months of mirror-image placement therapy,[5] and residence in an "independent living setting" (Angres, Talbott, and Bettinardi-Angres 1998:23). Following "step two" of AA's Twelve Steps, Talbott and his associates believed that "without surrender to [a spiritual] force, alcoholics and drug addicts continue to attempt recovery alone and thus feel in control, isolated, and sick. As a consequence, many of them experience relapse" (1998:96).

Like Talbott himself, the graduates of Talbott's impaired physicians programs were inspired by their own recovery from addiction to reorient their careers to care for other alcoholics and drug addicts. "These people came out bonded into AA," said one doctor familiar with this history. "And many of these people—surgeons, obstetricians, anesthesiologists ... internists, family physicians—decided that they wanted to work in the field of addiction" (AM/AP-19). Talbott himself wrote that "most [state-run treatment] programs were initiated by physicians who were in the recovery phase of their disease" (1988:216).

One serious problem faced by physicians in recovery was that alcoholics and drug addicts were stigmatized as social deviants, even when they recovered or reformed. This stigma remained strong in the 1970s despite resolutions from the American Medical Association that alcoholism was a medical problem. Additionally, organized medicine, virtually system-wide, still considered addiction treatment a misuse of precious time and resources. Acute care hospitals, chronic care facilities, and private practice groups were indifferent to drug treatment and resisted employing Talbott's former patients to provide it.

In response, in 1975, Talbott formed a loosely structured organization called the American Academy of Addictionology. Talbott's group "was all out of the recovering physician movement" (AMO-1), said a former addiction medicine official, and it was mostly comprised of Talbott's former patients. "They called themselves 'addictionologists,'" one physician remembered, "and they began spreading out around the country founding treatment programs for professionals, but also for others as well" (AM/AP-19). According to one former Academy officer, "in the very beginning, 90 percent of us were recovering, so we had a passion built out of our own illness, and I don't think that there is any question that that was a very powerful factor in getting these people together" (AM-11).

Recovering from drug abuse was not the only factor, however. Talbott wanted to credential doctors in recovery as "addictionologists." He wanted to "set up a certification" (AM/AP-19) and "start a specialty" (AMO-1) in addictionology that would be sanctioned by the American Board of Medical Specialties, "widely

recognized by physicians, healthcare institutions, insurers and patients themselves as an essential tool to judge that a physician has the knowledge, experience and skills for providing quality healthcare within a given specialty" (American Board of Medical Specialties N.d.).

Sowing the Seeds of Unity

Eager to get to work, Talbott met with Emanuel Steindler to confirm the American Medical Association's commitment to impaired physicians. Talbott was surprised to learn from Steindler that the California Society was also planning to certify and credential doctors in the addictions. Steindler therefore suggested that Talbott speak with Gail B. Jara, the California's Society's Executive Director. Talbott told Jara that he was looking for "the right people in California" to discuss creating a medical specialty in addictionology. Jara recommended Jess W. Bromley.

Bromley, an active member of the California Society and AMSA, tried to stop Talbott from moving forward. "That's not a good idea…. Don't do it that way" Bromley insisted. "Because if you do it that way you're going to splinter [addiction medicine]. What we need is to bring everybody together" (AMO-1). Bromley was not the only person worried about Talbott's plan. "It was around this time that AMSA got concerned. And the California Society … got concerned because Talbott appeared … to be … set[ting] up an adversarial group of physicians" (AM/AP-19).

In 1982, Talbott incorporated the American Academy of Addictionology after initially agreeing to put his plans on hold. He accused AMSA and the California

Society of dragging their feet on certification and medical specialty recognition. To prevent Talbott from dividing the field any further, and to signal to organized medicine how mainstream addiction medicine had become, the California Delegation to the American Medical Association House of Delegates, led by Bromley, introduced a resolution to arrange a meeting to create one national organization for the field of addiction medicine.

Dr. Stanley Gitlow, Ruth Fox's successor as president of both the New York Society and AMSA, did not support the resolution's initial language. Gitlow argued that AMSA already was *the* national organization. A revised resolution read that "the American Medical Association convene a meeting of appropriate organizations for the purpose of encouraging an *existing professional society* [emphasis added] to include a focus not only on alcoholism but also on other drug dependencies" (American Medical Association 1982:328). This decree led to two "Unity Meetings" in 1983 ("ASAM Introduction" 1997), the same year that AMSA, with 820 members (Galanter and Bean-Bayog 1989), separated from the National Council on Alcoholism.

The Addiction Medicine Unity Meetings

The first Unity Meeting was a two day conference at the J & R Kroc Ranch in Santa Barbara, California. The Kroc Ranch was owned by Joan B. Kroc, the philanthropist and widow of McDonald's Restaurant founder Ray Kroc.[6] Bromley, Jara, Talbott, and Dr. David E. Smith, founder of the Haight Ashbury Free Clinics in San Francisco, California, organized the meeting. Talbott was asked to chair the

event to "recognize the work he had started in Georgia" (AMO-1) and to quell any remaining urge he had to seek board recognition for addictionology. Representatives from AMSA, the National Council on Alcoholism, the American Medical Association, the Association for Medical Education and Research in Substance Abuse,[7] the American Psychiatric Association, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism also attended the meeting.

The agenda included promoting cooperation between AMSA, the California Society, and the American Academy of Addictionology, medical education and certification in substance abuse treatment, and recognition of addiction medicine physicians as board certified "specialists." This last item lacked support. "The prevailing undercurrent was this is all hypothetical pie in the sky bullshit," said one meeting participant. "This isn't going to happen…. You think the American Board of Medical Specialties is going to say 'oh please, come on in and have a medical specialty'? No. [We] just saw it as unrealistic" (AMO-1).

Disagreements typified the first Unity Meeting. "It's funny we called them Unity Meetings because there was certainly not unity," said one attendee. "There was a lot more disunity" (AMO-3). David Smith raised concerns about AMSA's reluctance to discuss drugs other than alcohol. Other physicians refused to isolate addiction treatment from primary care medicine. Daniel X. Freedman, president of the American Psychiatric Association from 1981 to 1982, reportedly claimed that addiction was a mental health problem that only psychiatrists should treat. Debate

over this issue got so intense that Freedman walked out of the meeting. One addiction medicine physician recalled the event:

> He suddenly decided this was something that the psychiatrists should be doing and he was … dead set against anybody but the psychiatrists doing it. I remember him getting up and giving a talk about how this was a … subspecialty of psychiatry and we should [not] even be talking about it except as a psychiatric subspecialty. So that was his reason for getting up and walking out (AM-11).

After the first Unity Meeting, AMSA invited the California Society and the American Academy of Addictionology to become part of its national organization. In October of 1983, the second Unity Meeting addressed the details of this merger. Drs. Stanley Gitlow and Maxwell Weisman represented AMSA while Bromley, Jara, and Smith represented the California Society. Talbott, of course, also attended. The discussions focused on the California Society certifying physicians in addiction medicine, medical education and public policy, incorporating other drugs into AMSA's agenda, and the role of impaired physicians in the organization. David Smith, himself a recovering alcoholic (see Sturges 1993), believed that doctors in recovery in the separate alcoholism and drug fields could work together to reduce the remaining tension between AMSA and the California Society.

AMSA's concerns about focusing on drugs other than alcohol were partly economic. According to one physician, "there was always a feeling among the New York group [i.e., AMSA] that … government money went much more to drugs than

to alcohol, … and that if alcohol merged with drugs … alcohol will be [a] submerged animal—no money will go towards alcoholism" (AM-5). An AMSA member said that "as long as we could keep alcohol and drugs separately funded we had a fighting chance. Once they decided that the funding should be mixed … it was sort of like throwing a steak into the backyard with a Great Dane and a Chiwawa and saying you guys fight it out. And we were the Chiwawa" (AM-6).

AMSA's financial worries, however, exposed another issue that a former president of the California Society raised:

> There were people, particularly in the New York group [i.e., AMSA], who said, 'what, we're going to [be] … taking care of heroin addiction?... Methadone maintenance? We're going to take those people in with us?' There was a handful of snobs who … were mostly recovering people, Alcoholics Anonymous-type folks who did not want to amalgamate the druggies into the drunks … [for] failure to recognize that the addiction was an addiction was an addiction…. There was some snobbery involved and … they [physicians in recovery] didn't want more stigma (AM-2).

The National Council on Alcoholism worked closely with AMSA to destigmatize chronic drinking. Some doctors in the California Society believed that AMSA physicians who were recovering from alcoholism influenced the organization to ignore drug abuse for fear that alcohol addiction would be restigmatized after decades of medical and public policy advances.

Debate on this issue finally ended when AMSA, after the second Unity Meeting, agreed to add other drugs to its national agenda. With almost 2,000 members, "that was the … bitter pill that [AMSA] had to swallow" (AMO-1). AMSA, the California Society, and the American Academy of Addictionology also agreed to focus on the following four issues: medical education in the addictions, physician credentialing and certification, nomenclature, and public policy. To facilitate this work, AMSA's Committee for Organizational Restructuring and Expansion (CORE) proposed splitting the country into regions. Each region would have an administrator who sat on a national board of directors, thereby assuring a representative voice for every member in the national society. CORE also proposed establishing state chapters of AMSA to increase its membership. In 1985, the year AMSA was renamed the American Medical Society on Alcoholism and Other Drug Dependencies, the California Society became its first state chapter.

"Self-Designated" Medical Specialty Status

In 1988, the American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) won a seat in the American Medical Association House of Delegates. The field of addiction medicine, represented by Jess Bromley and David Smith, now had a voice in organized medicine. One year later, with 3,000 members (Galanter and Bean-Bayog 1989), AMSAODD became the American Society of Addiction Medicine. Some members of the organization expressed concern that the term "alcoholism" was omitted from the society's new name. After

all, Ruth Fox and Marty Mann originally intended to help alcoholics. According to Bromley, however:

> The emerging specialty of addiction medicine encompasses the clinical management of … addiction to all drugs, drugs as old as alcohol and as new as tomorrow's 'designer drug,' as prevalent as nicotine and as esoteric as sufentanil. Addiction medicine includes research into neurochemistry, genetics, and new pharmacological treatments; the study of patterns of addiction; and new methods of treatment (1992:1531).

In 1990, amid this broader focus, the American Medical Association classified addiction medicine as a "self-designated medical specialty" (signified by the code "ADM") in a resolution introduced by the American Society of Addiction Medicine (see American Medical Association 1990). The American Medical Association describes self-designated medical specialties as follows:

> Self-Designated practice specialties/Areas of Practice (SDPS) … have historically related to the record-keeping needs of the American Medical Association and do not imply "recognition" or "endorsement" of any field of medical practice by the Association. The fact that a physician chooses to designate a given specialty/area of practice on our records does not necessarily mean that the physician has been trained or has special competence to practice the SDPS…. Although studies conducted by the U.S. Health and Human Services Bureau of Health Professions show that most practice specialties are consistent with physicians' graduate medical training

> and/or board certification, a practice specialty does not warranty special skill to practice in that specialty" (American Medical Association, as cited in personal communication, AMO-3, August 2, 2005).

One former addiction medicine official conceded that the "AMA's recognition doesn't mean much … [except that] you'll get counted…. People [can] say, 'I'm an addiction medicine specialist'" (AMO-1). A prominent psychiatrist in the addictions clarified this comment. "The American Medical Association is a professional guild. It is not the American Board of Medical Specialties…. It's not a high-level specialty-credentialing board" (AP-14).

Self-designated medical specialty status and representation in the American Medical Association House of Delegates nevertheless signaled that addiction medicine was a part of mainstream medicine—the medical treatment of addiction was "remedicalized" just as Bromley and others wanted. However, the true measure of status in American medicine is recognition from the American Board of Medical Specialties, the last word in physician credentialing. The American Board of Medical Specialties did not recognize addiction medicine.

Notes

[1] In 1974, the American Medical Association drafted the Disabled Doctors Act in response to addicted physicians. This legislation recommended that all health care professionals must report physicians with substance abuse problems to the appropriate medical authorities. The Disabled Doctors Act also stipulated that addicted physicians must seek treatment and be disqualified from practicing medicine if their drug abuse continues. "Sick doctor statutes" in Florida and Texas initiated the Disabled Doctors Act. "The 'sick doctor statute' defines the inability of a physician to practice medicine with reasonable skill and safety to his patients, because of one or more enumerated illnesses. It eliminates the need to allege or prove that a physician's clinical judgment was actually impaired or that he actually injured a patient. The defined inability can be the result of organic illness, mental or emotional disorders, deterioration through the aging process, or loss of motor skill. Further, the inability can arise from excessive use or abuse of narcotic drugs and chemicals, alcohol, or similar types of material." See American Medical Association Council on Mental Health, "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence" (1973), 686. See also Sargent, "The Impaired Physician Movement: An Interim Report" (1985).

[2] R. Brinkley Smithers, the financier of the alcoholism movement, funded the Smithers Alcoholism Treatment Center. The Center was built with a $10 million grant from Smithers himself to St. Lukes-Roosevelt Hospital in New York City. For more information, see White, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (1998).

[3] Dr. Clarence Pearson founded International Doctors in Alcoholics Anonymous in 1949. Currently the organization has approximately 5,000 members.

[4] In 1950, the Yale Section of Alcohol Studies was renamed the Yale Center of Alcohol Studies after sociologist Selden Bacon replaced E. M. Jellinek as Director. In 1962, the Yale Center moved to Rutgers University in Piscataway, New Jersey. As Yale evolved from applied research, the University's leadership grew increasingly concerned about the stigma the Yale Center caused the Ivy League institution. See Page, "The Alcohol History Collection at the Center of Alcohol Studies: A Valuable Resource on American Temperance and Prohibition" (2005); White (1998).

[5] Mirror-image placement therapy involves patients helping other patients understand the effects of drug use on themselves and their loved ones. See Angres, Talbott, and Bettinardi-Angres, *Healing the Healer: The Addicted Physician* (1998).

[6] Joan B. Kroc supported many philanthropic activities related to addiction. Why she agreed to host the Unity Meetings is not clear. However, one addiction medicine physician reported that Ray Kroc died an alcoholic.

[7] The Association for Medical Education and Research in Substance Abuse was founded in 1976 by physicians in the Career Teacher Program, a federal grant initiative for medical school faculty to develop and teach substance abuse curriculum in their home institution. Currently the organization supports medical training in the addictions for health care professionals. See also Chapter Five, note 7.

CHAPTER FOUR

CERTIFYING EXPERIENTIAL KNOWLEDGE

What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset.

—Foucault ([1963] 1994:xix)

As addiction medicine reorganized after the Unity Meetings, a Committee on Credentialing headed by Harvard University psychiatrist Margaret Bean-Bayog began designing an exam to identify "expertise" in the field. The addiction medicine certification exam was actually born in California in the early 1980s.

The Betty Ford Legislation

In the late 1970s, First Lady Betty Ford underwent treatment for alcohol and prescription drug abuse at the United States Naval Hospital in Long Beach, California. Mrs. Ford brought high-profile attention to the failures of addiction treatment in California. Accordingly, she and her lead physician, Dr. Joseph Cruse of Eisenhower Medical Center (Cruse later became the founding medical director of the Betty Ford Center), campaigned for specialized hospitals for addicts. These facilities would be more effective, Ford and Cruse argued, if they were separated from larger, acute care general medical facilities. In 1981, with support from philanthropist Leonard Firestone of the Firestone Tire and Rubber Company and other "movers and

shakers" (AMO-1) in California, the California state legislature passed the "Betty Ford Legislation" to build the hospitals that Ford and Cruse recommended.

The California Department of Health Services, the state agency responsible for licensing hospitals, stipulated that only physicians with "expert knowledge" in drug abuse would be permitted to direct the new facilities. However, the Department neglected to define what "expert knowledge" meant or how it should be assessed. "What is the measure? What is the yardstick going to be?" asked someone familiar with the Betty Ford Legislation. "Here is your opportunity, California Society…. You are the specialty society in California and you have been for eight or nine years now. If you say they [physicians who direct the hospitals] are 'knowledgeable,' then the state of California will probably take your word for it because who else is going to say it" (AMO-1)?

In 1982, led by Dr. Anthony Radcliffe, one of California's most respected addiction specialists, the California Society began constructing a certification exam for physicians in addiction medicine (Heilig 1993). The state of California did not officially endorse the test, but it was a standardized measure of medical expertise on substance abuse as required by the California Department of Health Services. Lawyers from the California Medical Association told the California Society how to describe the exam:

> The lawyers [said] the danger is that you overstep your bounds and try and make this exam into something more than it is. If you're going to say that this is [the] California Society recognizing and certifying these people as having

> met standards that the California Society establishes, then you're fine. If you advertise it as something that the state of California will recognize, then you'll get into trouble…. Don't say that it's more than it is and you'll be fine (AMO-1).

In 1983, the California Society administered the exam to over 100 physicians "to identify a body of knowledge, mastery of which would assume that a physician had attained knowledge relevant to the diagnosis, management, and treatment of addictive disorders" (Schnoll, Durburg, Griffin, Gitlow, Hunter, Sack, Stimmel, deWit, and Jara 1993:125). One year later, 100 more doctors took the test. Still, leaders of the California Society such as Gail Jara dismissed the exam's chances of becoming a national "yardstick" (AMO-1) to measure medical knowledge about addiction. "Yet everybody knew that had to happen. But it didn't seem like it was doable" (AMO-1).

On the contrary, in 1986 the American Medical Society on Alcoholism and Other Drug Dependencies adopted the California Society's exam and administered it nationally. Restructured "to identify those physicians who … have shown a mastery of the body of knowledge that has been amassed in this field" (Schnoll et al. 1993:132), physicians who sat for the exam needed to be a licensed medical practitioner, actively involved in addiction treatment, and a "good standing" member of the field (Galanter and Bean-Bayog 1989). About 900 physicians took the exam and 735 passed. Most of these doctors practiced general medicine, family medicine, psychiatry, or internal medicine. Others were surgeons, pediatricians, gynecologists,

and pathologists. Sixty-five percent of the examinees were certified by the American Board of Medical Specialties in their chosen medical discipline. Forty percent of the examinees held faculty positions in medical schools and one-third published scholarly work on addiction (Galanter and Bean-Bayog 1989).

Credentialing Addiction Recovery

One prominent addiction medicine physician remembered the doctors who took the certification exam in the early years as "a crazy bunch of people" from disparate medical backgrounds. There were "anesthesiologists galore," she claimed, "[and] a handful of people who were pathologists who didn't deal with 'live ones' at all. We even had a couple of forensic pathologists which I thought was great sport. Can you think of better people to be counseling you? But there they were. So it's been a grand hodge-podge" (AM-6).

This "hodge-podge" included physicians recovering from addiction. Estimates vary as to the exact number, but it was probably high for several reasons. First, recall Dr. Marc Galanter's comments about the role physicians in recovery played in the development of the New York Society and that organization's longtime link to the National Council on Alcoholism which likely attracted more doctors in recovery to addiction medicine. Second, similar to G. Douglas Talbott, doctors in the impaired physician movement surely felt compelled to specialize in the medical treatment of addiction. In fact, after the addiction medicine Unity Meetings in 1983, about one-third of the American Medical Society on Alcoholism and Other Drug Dependencies was comprised of recovering addictionologists. Lastly, physicians in

recovery sat for the addiction medicine certification exam in response to the poor drug treatment they received from psychiatrists. According to one recovering physician:

> One of the reasons that many of us got certified back in the 1980s was that we felt psychiatry as a field had just really … missed the boat in the understanding, diagnosis, and treatment [of addiction], and certainly in terms of the psychological theories. I mean that's nothing new. Psychiatry misses the boat on schizophrenia, depression, and a lot of other things.... We found colleagues [in addiction medicine] who could really speak the language of treatment and [who] were really concerned with getting people sober (AM/AP-22).

Indeed, former physician-addicts increasingly encountered one another at addiction medicine events. In 1986, for example, the American Medical Society on Alcoholism and Other Drug Dependencies began offering review courses for its certification exam.[1] One doctor in recovery spoke about a review course in the late 1980s where there was an Alcoholics Anonymous meeting in the basement of the hotel that hosted the event:

> There were probably 150 of us in that course…. So I showed up for [the Alcoholics Anonymous meeting], being a recovering person myself, and almost everyone from upstairs was downstairs. Out of the 150 who were there [for the review course], I would say there were about 120 in that [Alcoholics Anonymous] meeting, which was a real eye-opener. So the first five or 10

> years that I was doing this, most of the other doctors that I talked to were like me—they were just old drunks who sort of got into the business sideways (AM/AP-22).

Physicians in recovery were drawn to addiction medicine for many reasons. One of the most important reasons related to Emanuel M. Steindler's hope that impaired physicians returned to medicine and to Talbott's aspirations for addiction medicine in particular.

Addiction can so thoroughly spoil a medical career that physicians who get sober need to "start up fresh in something" (AM-5). Younger physicians can begin residency training anew. But for some of them, and for most older doctors who recovered in their 40s and 50s, starting or continuing residency training that was disrupted by drug abuse was difficult, costly, and time-consuming. Not completing a residency, however, came with serious professional consequences.

To be certified as a medical specialist in any field by the American Board of Medical Specialties, physicians must complete residency training that is approved by the Accreditation Council for Graduate Medical Education, the organization that sanctions all residency and post-residency medical training programs. Afterward, physicians are eligible to sit for their specialty field's board exam and are considered board certified if they pass this exam. But what about doctors whose residency training was interrupted by addiction? As one former addiction medicine official noted, "they're not board-eligible, they're not anything, really, and they can't really call themselves specialist." In other words, if these physicians determined that it was

too late to finish a residency or to start another one, “the door is irrevocably shut on them ever having a specialty” (AMO-1).

Except perhaps, in addiction medicine, their new passion. But addiction medicine was not board recognized. Therefore, as the official just quoted explained:

> Here we have this community of people within the recovering community who are becoming interested in the treatment of alcoholism and other drug dependencies. They do it for a long time…. They do a lot of continuing medical education. Maybe they even do some research…. They become very, very knowledgeable and very well-respected. Where are they going to get the kind of recognition that they want within medicine that comes with being boarded? They are going to get it with the new specialty in the field in which they happen to be very expert and knowledgeable. So there is that big important thread that pushes for this [board recognition] (AMO-1).

The expectation inside addiction medicine was that its certification exam, a “private credential” (see Freidson 1986), would help the field acquire board recognition. Addiction medicine physicians believed that their combination of knowledge and experience could provide the basis for establishing a new board specialty in their discipline. But meetings between addiction medicine officials and representatives from the American Board of Medical Specialties, including talks with the American Board of Preventive Medicine about creating an addiction medicine subspecialty, produced no results. Most medical boards, 24 in total, had no interest in offering education on drug abuse to their trainees. Moreover, to acquire specialty or

subspecialty recognition from the American Board of Medical Specialties involved rigorous medical, scientific, bureaucratic, and administrative requirements (see American Board of Medical Specialties 2005; American Board of Medical Specialties 2006). "There was a process that all specialties … or all subspecialties had to go through to get [board] approval," one observer noted. "They [addiction medicine] weren't really going that route" (AP-7).

The "Alternate Pathway" to Certification

By 1988, roughly 1, 800 physicians were certified in addiction medicine (see Table 2 for more information), but the field was still fixed on acquiring recognition from the American Board of Medical Specialties. Consequently, in 1989, after the American Society of Addiction Medicine (ASAM) formed, top officials from the organization began to closely monitor the physicians who sat for its exam. "The only way we're going to [get board recognition] is if we keep our standards at the same level as other [medical specialty] boards," ASAM's leaders argued, "which means you've got to have a residency. Don't come to me if you don't have a residency … because you're never going to get there [achieve board recognition] if you try to take everybody with you" (AMO-1).

In 1990, the year the American Medical Association acknowledged addiction medicine as a "self-designated medical specialty," ASAM's Board of Directors ordered that all applicants for the certification exam must be residency trained. "The idea behind [this directive] was … if somebody has done any kind of residency [in any medical specialty], then that shows that they have some … medical knowledge or

stability" (AM-24). But there was a problem. According to one addiction medicine physician:

> We were running into this group that could sit for the exam that didn't necessarily seem medically qualified. Some of them … had real colorful histories, they moved around a lot, and it was like, 'well, maybe I'll try this.' But they met the [residency] criteria. [Others without residency training] were some of the leaders in the field—people that were publishing stuff [but who] could not be certified…. Some people were getting [certified] that did not seem nearly as good as the people we were leaving out…. How much medicine does a radiologist actually know? What qualifications does this person have (AM-24)?

These concerns gradually led to "a great backlash" (AM-2) against excluding otherwise qualified physicians without residency training from sitting for the addiction medicine certification exam. To resolve the issue, ASAM's Credentialing Committee proposed the "alternate pathway" to certification. Under this designation, physicians without residency training but with clinical experience in addiction treatment could sit for the exam.[2] ASAM's Board of Directors was initially cold to the idea, convinced that it would hurt the field's chances to become board recognized. "[We] cannot lose the [residency] criteria at this point," opponents of the alternate pathway said. "We have got to make the criteria more difficult if we're going to do this [get board recognition]" (AM-24). The Board of Directors conceded and

ultimately ASAM instituted the alternate pathway to certification for the 2004 and 2006 exams cycles for 29 physicians, 23 of whom passed the exam.

The alternate pathway's future is uncertain. "Somebody is going to have to bring it up and be willing to fight for it" (AM-24). A former president of ASAM, himself a recovering alcoholic, explained why this fight is important:

> The recovering physician really is the spiritual foundation of addiction medicine because that's really what got it started…. So I want to make sure that we … don't forget our history and … cut off them. It comes up in … [the] alternative pathway to certification. [ASAM has] a very well-defined certification process now, but I would say don't cut off the alternate path for recovering physicians as long as recovering physicians get the necessary additional training (AM-15).[3]

The additional training to which this physician referred does not exist because "[ASAM] didn't have … the connection at the medical schools, the influence to get it done" (AM-24).

The "Catch-22"

A physician who played a key role in developing the addiction medicine certification exam said the following about medical training in the field:

> The certification craze … took off with a big bang. But it wasn't followed up with training. It wasn't followed up with teachers who … trained other people

> so that when they retired those people could take over…. I [also] didn't see research tied to what we were teaching as much as it needed to be. And that's the piece that I think is missing. We don't train our doctors to work in addiction medicine. I don't think it's changed that much. I don't see a lot of new training programs out there, that's for sure (AM-4).

Without recognition from the American Board of Medical Specialties, addiction medicine could not, nor can it still, set up departments of addiction medicine in medical schools through which training in the discipline can be offered. "So this is where we have the Catch-22," declared one addiction medicine physician. "How do you tip the scales? What is going to be the thing that changes the paradigm? There's going to have to be something that tips the scales, because … we have … no departments, no primary residencies, few fellowships" (AM/AP-16). According to one former ASAM president, "if we don't get the training we're shooting ourselves in the foot. I can't imagine any type of specialty that would hold itself out to be a specialty if they didn't train [for] their future. It doesn't make sense to me" (AM-4).

Even if departments of addiction medicine did exist, one doctor stated, "I don't see medical students coming out of school and going into … a residency in addiction medicine" (AM/AP-17). An addiction medicine physician explained why. "We simply don't have enough data to justify a three year residency program. I could teach most people what they needed to know about alcoholism in about a year. I could stretch it out a little bit by making them do research, but it ain't right" (AM-6).

Indeed, specialty training in the addictions is typically done as a year-long fellowship after physicians complete a residency program. In 1990, ASAM developed "Guidelines for Fellowship Training Programs in Addiction Medicine" (see Bromley 1993). However, the organization does not record how many addiction medicine fellowships currently operate.[4] Additionally, "in the absence of having a subspecialty [or] a sanctioned board, your fellowship has no standards that it has to adhere to. So some … individuals have [completed] addiction medicine fellowships which have no established criteria" (APO-23).

"We don't have to rely on the residency [or the fellowship]," said an ASAM-certified physician. "The exam is hard and if [physicians] can pass the exam then they have to know something" (AM-24). A colleague disagreed. ASAM certification is only enough in that "otherwise that [recovering] anesthesiologist is going to say, 'I practiced anesthesia for 15 years and they threw me out…. [But] now I have my license again and I'm just going to do addiction medicine. And the training, don't need any [because I] had the experience'" (AM-6). In other words, when doctors become addiction medicine physicians because they recovered from drug abuse, at least they are forced to learn "something" (AM-6). Lastly, "insurers … recognize [the addiction medicine exam]," said another treatment professional, "but it's not the American Board of Medical Specialties. It's not a board certification" (AP-14). ASAM acknowledges exactly this:

> [The addiction medicine] examination is a test of knowledge. While it does not certify clinical skill or competence, it does identify a physician who has

> demonstrated the degree of knowledge in the diagnosis and treatment of alcoholism and drug dependencies commensurate with expertise in the field as defined by ASAM. The examination is not a Board examination. ASAM is not a member of the American Board of Medical Specialties, and ASAM certification does not confer board certification (N.d.-b:5).

"The clinical gaze is not that of an intellectual eye.... It is a gaze of the concrete sensibility, a gaze that travels from body to body…. '[T]heory falls silent or almost always vanishes at the patient's bedside to be replaced by observation and experience'" (Foucault [1963] 1994:120). The absence of formal medical training programs in the addictions for ASAM physicians, particularly for doctors in recovery, underscores their experiential knowledge, or "a high degree of conviction that the insights learned from direct participation in a situation are truth, because the individual has faith in the validity and authority of the knowledge obtained by being a part of a phenomenon" (Borkman 1976:447). As one treatment expert stated, "[ASAM] got its start out of taking care of sick people and helping the suffering addict and alcoholic. It was not an organization that was born in the world of academics. It was not born out of research. It was born out of taking care of sick people" (AM/AP-22). Scientific knowledge, however, generates institutional power in organized medicine and "[holds] a privileged status in the hierarchy of belief" (Starr 1982:4).

Table 2

Addiction Medicine Certification Exam Results 1986-2006*

Exam Year	Number of Examinees	Number of Physicians Certified	Percentage of Physicians Certified
1986	905	688	76
1987	680	537	79
1988	672	548	83
1990	586	492	84
1992	334	297	89
1994	211	175	83
1996	185	146	79
1998	239	191	80
2000	248	213	86
2002	266	226	85
2004	341	300	88
2006	336	282	84

*Source: American Society of Addiction Medicine

Notes

[1] "The … review course in Addiction Medicine is designed to provide a review of the core content of Addiction Medicine…. Participants who complete the Review Course should be able to demonstrate knowledge of current clinical practice across the spectrum of Addiction Medicine." See American Society of Addiction Medicine, "ASAM Review Course in Addiction Medicine" (2004).

[2] The requirements to sit for the certification exam in addiction medicine include graduation from an accredited medical school, a medical license, good standing in the medical community as evidenced by recommendation letters from medical colleagues, board certification in a medical specialty or completion of an accredited residency training program in a medical specialty, full time involvement in the substance abuse field for one year, and 50 hours of continuing medical education in the addictions. Under the alternate pathway designation, physicians needed to meet the first two criteria above and be in good standing in the medical and addictions community according to peer recommendations. Additionally, alternate pathway designees needed to have: (1) reference letters from two ASAM-certified physicians who confirmed the applicant's medical standing and verified that a considerable part of his or her medical practice related to addiction; and (2) 250 hours of continuing medical education on substance abuse accumulated no more than five years prior to the exam. See American Society of Addiction Medicine, "Booklet of Information for the 2006 Certification Examination and the 2006 Recertification Examination" (N.d.-b).

[3] "[Addiction] was the reason that many of these guys had not completed their residency," claimed a member of ASAM's Credentialing Committee, "but [the alternate pathway] was not out of a feeling of empathy because of that. The impetus was we got this group of really sharp, astute, experienced people who are dropping out of ASAM, not on any committees, not putting in their two cents worth because we won't let them be certified" (AM-24). At the time of this writing, the alternate pathway to certification is not available for the 2008 exam.

[4] In a "note for non psychiatrists" regarding addiction medicine fellowships, ASAM tells physicians that "we are continuing to try and build a database of all fellowships available, but in the meantime, you should try to apply for some of the psychiatric positions as many of those are open to non psychiatrists." See American Society of Addiction Medicine, "Addiction Medicine Fellowships" (2005).

CHAPTER FIVE

THE ADVENT OF ADDICTION PSYCHIATRY

People want their own professional standing. They want to be recognized as experts in an area. People will pay more attention to … 'specialists' in an area. The idea of professionalism, you know? We're professionals and you're not.

—An addiction psychiatrist (AP-9)

The formation of ASAM in 1989 signaled that the medical treatment of addiction was a multidisciplinary field of specialized expertise. However, the fact that addiction medicine physicians practiced general and internal medicine, surgery, pediatrics, and even gynecology (see Galanter and Bean-Bayog 1989) overshadowed the distinct contribution psychiatrists believed they too could make to addiction treatment. In the early 1980s, psychiatrists accounted for one-third of ASAM's 820 members. By the end of the 1980s, psychiatrists represented 28 percent of all applicants for the certification exam in addiction medicine (Galanter and Bean-Bayog 1989; Galanter, Blume, and Bissell 1983).

But psychiatrists were not prepared to treat addiction. In 1986, psychiatrist Marc Galanter of the New York University School of Medicine wrote that "mainstream mental health clinicians have not yet addressed their responsibilities in this area, even though addictive illness is the most common psychiatric disorder" (1986:769). Medical training in substance abuse lags behind training for depression and schizophrenia. "Until mental health professionals learn to use the proper tools to

initiate and sustain abstinence in alcoholic and drug-dependent patients," Galanter argued, "the field will be deficient in meeting one of its primary responsibilities" (1986:769). A group of psychiatrists in the American Psychiatric Association filled these training and treatment voids.

Goode argues that "the most severe skirmishes in the process of institutionalization … occur between the new profession and the occupations closest to it in substantive and clientele interest" (1960:903). This chapter details the development of addiction psychiatry and the origins of the American Academy of Addiction Psychiatry. The field of addiction psychiatry was the invention of a small, influential group of academic psychiatrists who were convinced that their psychiatric training and knowledge about substance dependence were essential to addiction treatment. At the core of their scholarly and clinical interests, however, addiction psychiatrists were troubled by what addiction medicine physicians and recovering addictionologists knew medically about drug abuse and how they applied this knowledge to treatment. Armed with the scientific literature on addiction and exclusive fellowship training programs, this concern prompted the psychiatrists to acquire subspecialty recognition for addiction psychiatry from the American Board of Psychiatry and Neurology, establishing what Goode (1960) calls their "right to responsibility" for the medical treatment of addiction.

Professional Powerlessness

In 1982, one year before the addiction medicine Unity Meetings, the American Psychiatric Association surveyed the clinical interests of its members. Out

of 28,000 psychiatrists, 4, 657 identified addiction (Miller and Frances 1986)—formally labeled "substance dependence" in the third edition of the Diagnostic and Statistical Manual of Mental Disorders, American psychiatry's official text of mental health nomenclature (see American Psychiatric Association 1980).

The alcoholism and drug abuse committees of the American Psychiatric Association looked closer at these psychiatrists. A study authored by Sheldon I. Miller and Richard Frances (1986) found that 40 percent of psychiatrists devoted 11 to 30 percent of their clinical time to substance abuse while 16 percent dedicated 31 to 70 percent of their medical practice to addiction. Fewer than 10 percent of psychiatrists gave over 70 percent of their time to addiction treatment. In addition, over two-thirds of psychiatrists strongly agreed that alcoholism and substance abuse are psychiatric disorders while 58 percent reported that addiction is a primary disease. Most psychiatrists, 88 percent, strongly agreed that addiction is treatable; 86 percent "often" encouraged their patients to go to self-help groups like Alcoholics Anonymous. Lastly, interest in addiction among psychiatrists stemmed from their seeing a need for treatment or from a training or mentorship experience. "Interestingly," Miller and Frances wrote, "only 20.6% of the respondents list personal or family experience as having been a stimulus or a source of interest" (1986:190).

Despite their attention to substance abuse, and notwithstanding the claim from Miller and Frances that mental health professionals "are becoming active in assuming their place in teaching, research, and treatment roles" (1986:196), psychiatrists

working in the addictions field felt marginalized by their mainstream mental health colleagues. One of these psychiatrists explained:

> [We] felt marginalized … by the rest of psychiatry. We were sort of odd ducks. We didn't get a lot of training in [addiction]. Many psychiatrists thought it was not respectable. They had biased attitudes towards it. It didn't get a lot of play in the training programs…. Those of us who really got into it saw that this is a psychiatric disorder [and that] we ought to be leading the way in this. We have a lot to offer. So we felt marginalized within our own specialty (AP-8).

Miller and his colleagues felt like "outsiders" and "not immune from the same stigma that has tracked addiction problems in patients and those who have been working in the addiction field" (see Pichot, Starck, Harris, and Benzick 1997).

These feelings of professional powerlessness, however, derived from an added source:

> We were [also] feeling marginalized and threatened by those people who called themselves 'addictionologists.' They were by and large … doctors who were in recovery, many of whom had been treated by psychiatrists or in psychiatric hospitals and were very disparaging of their treatment…. [Psychiatrists] all failed them miserably. So they had their own agenda … vis-à-vis psychiatry (AP-8).

This psychiatrist credited addiction medicine physicians like Ruth Fox and Jess W. Bromley for "picking up the ball" when few doctors would. But in the 1970s and 1980s, G. Douglas Talbott became a leading force in addiction medicine with an "anti-psychiatry bias" (AP-8) to acquire recognition for addictionology from the American Board of Medical Specialties. "And that was one impetus for those of us who were feeling like this was really a realm psychiatry had to get on top of," said the same psychiatrist. "We were now threatened … [and felt] the pressure to set up a separate specialty" (AP-8). Indeed, "outside [the] self-help enterprise, at the more professional levels, the doctors who were really interested in alcoholism and addiction, … the ones in the trenches mostly, were people in recovery, and they kind of shaped the notion of what alcoholism is" (AP-8).

The Minnesota Model of Addiction Treatment

In the late 1970s and early 1980s, "when all this unrest was first bubbling up" (AM/AP-17), 28-day inpatient treatment centers dotted the country and followed the Minnesota Model of addiction treatment. The Minnesota Model originated in the 1940s in three residential treatment centers in Minnesota: Pioneer House, Hazelden, and Willmar State Hospital.[1] "What emerged was the treatment of alcoholism as a primary disorder, the integration of A.A. concepts and practices within the treatment milieu, the utilization of a multidisciplinary team, [and] the inclusion of recovered alcoholics as volunteers and full time paid staff within that team" (White 2000a:18). White describes the impact of the Minnesota Model on addiction treatment after the 1950s:

> The Minnesota Model represented a radical shift from the prevailing view that alcoholism was both a hopeless condition and a reflection of moral inferiority. The Minnesota Model provided a marked contrast to the 'degradation rituals' that alcoholics were subjected to within the psychiatric asylums of the mid-20th century and the mutual contempt that had long marked the relationship between alcoholics and professional helpers (1998:209).

Addiction psychiatrists look back and argue that the directors of Minnesota Model facilities unconditionally accepted this approach, particularly the principle that "the most effective treatment for alcoholism includes an orientation to A.A., an expectation of 'Step work,' … and the creation of a dynamic 'learning environment'" (White 1998:209).[2] One psychiatrist said that Minnesota Model directors based their clinical judgment on the fact that "the 'founding fathers' [of the treatment centers] received their inspiration from old-timers from Alcoholics Anonymous, who got their inspiration from Dr. Bob and Bill W., who spoke to God. That's why it should be done [this] way" (AM/AP-17). Minnesota Model treatment was effective because the facility leaders and staff who recovered by it said it was.

"Behind the stage sets," however, there was no scientific evidence to support 28-day treatment. "I was looking at this," said the psychiatrist above "and thinking … we don't have any data to back up the idea that everybody needs 28 days of treatment" (AM/AP-17). Psychiatrists in the addictions did not consider the Minnesota Model "real medicine" based on "science" (AM/AP-17). They linked

substance abuse with mental illness, but who was qualified to evaluate depression, bipolar disorder, or schizophrenia in facilities without psychiatric leadership and staff support? According to one physician in recovery:

> If you go back 25 years, who were those doctors who were taking care of addicts and alcoholics? They were doctors like me who were drunks and junkies who needed jobs and who went to work in treatment centers doing histories and physicals and trying to recover from their own impairments…. Every single one of those places had a recovering physician as medical director and that's [one way] ASAM got started (AM/AP-22).

Another physician recovering from addiction said that "many people in recovery found themselves being asked to direct treatment programs. A lot of them … moved into certification … and participation with ASAM" (AM/P-18). In sum, Minnesota Model, 28-day treatment helped "kick off" addiction psychiatry (AM/AP-17).[3]

The American Academy of Addiction Psychiatry

In 1985, members of the American Psychiatric Association's committees on alcoholism and drug abuse, notably Richard Frances and Sheldon Miller, founded the American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA). AAPAA began as a small organization of about 150 psychiatrists who were stirred by "other" physicians who had come to "dominate the field excessively" and fueled by the contention that "substance use disorders are important aspects of psychiatry" (Miller and Frances 1986:196). AAPAA sought "to improve education, prevention,

treatment, and research in the field of alcoholism and addictions; to strengthen the training of psychiatrists in the addiction field; and to provide public information about the role of addiction psychiatrists" (Galanter and Frances 1992:1068).

AAPAA's objectives masked the apprehension among its leaders about recovering addicts who treated drug abuse. This concern even influenced the naming of AAPAA. "The reason why I wanted to have those letters ['AAPAA']," said one of the group's founders, "was … I wanted to [put] 'AA' around 'P' because the … vision was we're going to bring together AA and psychiatry—bring together the craft side of the field with the scientific side of the field and have the medical leadership of psychiatry kind of leading it" (AP-7). The "craft side of the field" included credentialed and non-credentialed drug abuse counselors, social workers, nurses, and Alcoholics Anonymous. But the suggestion is that the founders of AAPAA were also troubled about whether and to what extent physicians in recovery should provide addiction treatment.

Leading members of AAPAA—which in 1996 became the American Academy of Addiction Psychiatry, or "AAAP" so that addiction psychiatry could remain "shoulder to shoulder with AA" (AP-7)—reiterated this concern:

> AAAP … was a group of psychiatrists who became disillusioned with ASAM because they felt that politically ASAM was being dominated by the recovering community and by its affiliation with the National Council on Alcoholism and kind of anti-academic…. All of the founding big-shots of

> AAAP were academic psychiatrists. And the organization has continued to be dominated by researchers and academics (AM/AP-17).

A nationally known ASAM physician in recovery recalled the founders of addiction psychiatry saying, "'we're forming because ASAM was formed and is threatening our domain'…. There's absolutely no question the recovering physician in addiction medicine was used as a rallying cry to form addiction psychiatry" (AM-15). A prominent psychiatrist summarized that rallying cry like this:

> Sometimes they [physicians in recovery] were anesthesiologists [and] sometimes they were GP's [general practitioners]. After they got into trouble and … got into a recovery mode, they became addiction medicine specialists by passing the ASAM [exam] and getting active in ASAM…. At least a serious percentage of them, their knowledge base had to do with … personally having been addicted and then being in a recovery mode (AP-9).

Consequently, during the 1980s and 1990s, an antagonism developed between addiction medicine and addiction psychiatry, especially among the leadership and prominent members of each field's medical organization. "Psychiatrists felt that they were the ones who ought to provide all the treatment for addiction problems," said an ASAM-certified addiction psychiatrist. "And many ASAM members felt that they were the ones who should be providing the treatment" (AM/AP-19). One doctor spoke about the narrow-mindedness of physicians from both fields:

> There [was] a tremendous amount of prejudice on both sides. From the many members of the psychiatric community, … their general bias was that people in ASAM and addiction medicine specialists were not psychiatrists [and] basically a bunch of rather 'soft-brained recovereds' who weren't at all interested in science and thought that only AA would work. And from the other side there were the ASAM people who were in recovery who felt that the psychiatrists were a bunch of 'Johnny-come-latelies' who leapt onto the bandwagon because they saw some money in it [but who] were no more interested in treating alcoholics than treating anyone else (AM-5).

Psychiatrists in addiction medicine such as Marc Galanter, the only physician to serve as president of both AAAP (1991-1992) and ASAM (1999-2001), assured ASAM's leadership of no ill will.[4] However, influential and outspoken psychiatrists such as Sheldon Miller grew increasingly troubled by ASAM's efforts to acquire recognition for addiction medicine from the American Board of Medical Specialties. An ASAM officer explained the genesis of Miller's anxiety. It was a response to G. Douglas Talbott and to the tradition of recovery that the American Academy of Addictionology embodied:

> Basically you had all these recovering docs melded [into ASAM], and I think the New York academic psychiatrists who had been active in ASAM may have been reacting to that. So it [AAAP] was … [an] anti-non-academic and anti-recovery doctor movement…. I think your watershed event in history is … [that organization] forming itself (AM/AP-16).

The Path to Subspecialty Recognition

In 1991, another critical event in the history of addiction medicine and addiction psychiatry further increased tensions between the two medical fields. That year addiction psychiatry became a board recognized subspecialty under the American Board of Psychiatry and Neurology. This recognition formally differentiated—or "stratified by differential prestige" (Freidson 1986:211)—addiction psychiatrists from ASAM-certified physicians. This was precisely what the psychiatrists wanted to achieve.

The Scientific Literature on Comorbidity

Historically, remarked one psychiatrist, addiction treatment providers are not rigorous scholars. Drug and alcohol experts tend to devise their own "idiosyncratic and subjective impressions" (AP-8) of substance abuse—sometimes based on their personal experience—and overlook the possibility that some patients are not addicted at all. This results in poor treatment and is attributable to physicians who do not see "both sides of the coin" (AP-8), or the link between substance abuse and mental illness called comorbidity.

In 1990, the Epidemiologic Catchment Area (ECA) study broke new ground in this area of research (see Regier, Farmer, Rae, Locke, Keith, Judd, and Goodwin 1990; Regier, Myers, Kramer, Robins, Blazer, Hough, Eaton, and Locke 1984). Led by Daniel A. Regier, the Associate Director for Epidemiology and Health Policy Research at the National Institute of Mental Health, the ECA study found that 37

percent of individuals with alcohol problems and 53 percent of drug abusers had a mental problem such as schizophrenia, antisocial personality disorder, anxiety disorder, or affective mood disorder. Moreover, drug abusers were four times more likely to have a mental problem than those who did not abuse drugs. Additionally, over 22 percent of individuals with a lifetime mental disorder abused alcohol or were alcohol dependent while almost 15 percent of persons with mental illness were drug abusers or drug dependent.[5] In comparison, among those with no lifetime history of mental illness, 11 percent and 3.7 percent abused alcohol or drugs, respectively. Regier and his associates concluded that "mental disorders must be addressed as a central part of substance abuse prevention efforts…. For mental health professionals, it is also important to recognize the high rate of substance abuse disorders among those with severe mental disorders" (1990:2517).

A former president of AAAP explained how the comorbidity literature impacted addiction psychiatry:

> In the late 80s throughout the 90s, [there] were excellent methodological studies accounting [for] the various DSM [Diagnostic and Statistical Manual of Mental Disorders] diagnoses in the population. This showed a high rate of alcohol and drug problems … [and also] that … comorbidity was very, very common. So all of a sudden you're finding that … alcoholics and … drug addicts have a co-occurring psychiatric disorder. This gives us a real big foot in the door in addiction treatment (AP-8).

The ECA study and earlier comorbidity reports helped establish addiction psychiatry's "jurisdiction" (Abbott 1988) in drug treatment.[6] "Even if you accept the argument that we shouldn't call [addiction] a psychiatric disorder," said the psychiatrist above, "as it turns out, a very high percentage of these folks have a psychiatric disorder that's tied in with … their substance use disorder. So it made psychiatry's role a lot more obvious" (AP-8). According to another addiction psychiatrist, "what prompted [subspecialty recognition] was the very clear and emerging issue of comorbidity—clearly the 'dawn's early light' that substance use disorders are a psychiatric condition in which we have at least as much to say, if not more to say [compared to addiction medicine physicians], in terms of our training, our background, and our treatment armamentarium" (AP-12).

The Substance Abuse and Mental Health Services Administration (2002) which advocates for chemically dependent and mentally ill patients estimates that 6.6 million American adults with a mental disorder have a co-occurring substance abuse problem. "So the basic science," concluded one psychiatrist, "is pushing [addiction] more and more towards the psychiatric end of the specialty spectrum" (AP-8).

Medical Training for a New Generation of Addiction Psychiatrists

In 1990, the year the National Institute of Mental Health published the ECA study, AAAP proposed creating an addiction psychiatry subspecialty under the American Board of Psychiatry and Neurology to recognize psychiatric expertise on addiction (Galanter and Frances 1992). Marc Galanter stated that the task of this "certificate of added qualification" should be twofold. "First, it must provide a

sophisticated biopsychosocial research base on which clinical training and practice will be elaborated. Second, it must assure proper diagnostic and treatment skills in alcoholism and drug abuse to all medical trainees" (Galanter 1989:9). Specialized education and training in the addictions for a new generation of psychiatrists was critical to developing an addiction psychiatry subspecialty. "If psychiatry is to make a major contribution to this field," Galanter wrote, "its role in teaching physicians, especially psychiatric residents, must be an active one" (1989:38).

In 1987 and 1989, 27 and 34 fellowship training programs in the addictions operated nationwide (Galanter, Kaufman, Schnoll, and Burns 1991). Residency-trained physicians from any medical specialty could participate in these fellowships, but they predominantly served psychiatrists because only medical school departments of psychiatry sponsored them (Galanter and Burns 1993; Galanter and Frances 1992; Galanter, Kaufman, Schnoll, and Burns 1991). Other medical specialties, and hence their respective medical school departments, still considered addiction treatment "dirty medicine" (see Josiah Macy, Jr. Foundation 1973:2). Galanter, however, worried that the fellowships lacked a uniform structure: "a review of the particulars of the training format revealed a variety of teaching approaches, as well as a variety of services and curricula available for teaching, underlining the utility of developing consensus standards for curriculum so as to guide fellowship directors in their planning" (1991:3).

Accordingly, in 1991 the National Advisory Committee of the Center for Medical Fellowships in Alcoholism and Drug Abuse prepared national consensus

standards for fellowship training in the addictions (see Galanter, Kaufman, Schnoll, and Burns 1991). The Center for Medical Fellowships, directed by Galanter at the New York University School of Medicine, formed the National Advisory Committee in the late 1980s. Psychiatrists dominated this 23 member team of self-described "leading figures in academic medical training in the addiction field" (Galanter, Kaufman, Schnoll, and Burns 1991:2). It included Galanter, Sheldon Miller, Richard Frances, Edward Kaufman, and John N. Chappel, most of whom held prominent roles in AAAP. In fact, in 1987 AAAP co-founded the Center for Medical Fellowships whose National Advisory Committee developed the training standards for AAAP.[7] In other words, the organization for which the fellowship standards were written also founded, and their members occupied, the committee that wrote the consensus standards.

The National Advisory Committee designed the consensus standards to "provide an intellectual environment for acquiring the knowledge, skills, clinical judgment, and attitudes which are essential to ADA [alcoholism and drug abuse] practice" (Galanter, Kaufman, Schnoll, and Burns 1991:5). As head of the National Advisory Committee, Galanter outlined core competencies in evaluation and consultation, laboratory assessment, pharmacology, treatment modalities, and research: "the final product of the program should be physicians who can integrate the science and therapeutic techniques of addiction into their general medical knowledge, and who can become effective bedside teachers of their subspecialty discipline to others" (1991:9). These competencies matched the official fellowship training requirements of the Accreditation Council for Graduate Medical Education,

the organization that reviews and approves all medical training programs (Galanter, Kaufman, Schnoll, and Burns 1991).

The National Advisory Committee stated that its training standards could apply to any medical school department that offered residency-affiliated fellowships in the addictions. "[I]t was hoped that by requiring that fellowships be integrated into existing residency programs, a requisite level of commitment to existing approaches to postgraduate medical training would be established" (Galanter, Kaufman, Schnoll, and Burns 1991:4). However, when the National Advisory Committee developed the consensus standards, "[most] doctors belonged to specialty groups that couldn't have cared less about addiction medicine" (AM/AP-19). According to a former president of AAAP, "when we were founding the board in addiction psychiatry we initially reached out … to internal medicine, pediatrics, surgery, and tried to get the other … primary care specialties … to develop subspecialties of their own and they would come together in some kind of joint board. But the other specialties weren't interested" (AP-7). ASAM would have jumped at the opportunity to offer standardized fellowship training, but addiction medicine was not recognized by the American Board of Medical Specialties and thus lacked residency programs, which precede fellowship training, to offer.

Realistically, then, only departments of psychiatry could implement the National Advisory Committee's fellowship training standards for a board approved certification in addiction. This training was vital for a new generation of mental health professionals to, as Marc Galanter stated, "portend the availability of expert

addiction treatment and research in the future" (1993:1). Without the same institutional access, addiction medicine was left in the cold.

Board Subspecialty Recognition

Ten months after the National Advisory Committee issued its training consensus standards, the Group for the Advancement of Psychiatry (GAP) Committee on Alcoholism and the Addictions declared that psychiatrists had "reawakened" to the health consequences of drug abuse. The GAP committee consisted of AAAP officers and psychiatric experts such as Edward J. Khantzian, Richard Frances, Marc Galanter, Sheldon Miller, Edgar Nace, Margaret Bean-Bayog, Robert Millman, and John Menninger. In a position paper entitled "Substance Use Disorders: A Psychiatric Priority," the committee tied addiction to mental health: "the evidence to date suggests an intricate and not entirely uniform set of relationships between various patterns of drug abuse and the concurrent presence of other psychiatric disorders" (1991:1294). The GAP committee also called for more training in the addictions for psychiatry to fulfill its "critical role" in treatment: "as biopsychosocial phenomenon, substance abuse problems constitute a special and direct challenge to the psychiatrist, whose training, perspective, and competence should span all three domains" (1991:1298).

Most conspicuously, the GAP committee noted that "within the treatment system, 'addictionologists' of all disciplines have supplanted psychiatrists on the front lines" (1991:1292). This statement, a clear reference to physicians certified by ASAM, particularly those in addiction recovery, mirrored the assertion made by

Sheldon Miller and Richard Frances five years earlier about "other" professionals excessively dominating drug treatment (see 1986:196).

The same month the GAP committee issued its position paper, October 1991, the American Board of Psychiatry and Neurology launched the Committee on Certification of Added Qualifications in Addiction Psychiatry "to officially establish the field of addiction psychiatry as a definite area of subspecialization in psychiatry and to provide a means of identifying properly trained and experienced addiction psychiatrists" (American Board of Psychiatry and Neurology, Inc. 2005:18). Medical historian Rosemary Stevens might say that addiction psychiatry had found its "place in the sun" (1998:343). Galanter said it differently: "the establishment of a Certificate of Added Qualifications (CAQ) by the American Board of Psychiatry and Neurology … clearly legitimates the role of addiction psychiatry in the medical mainstream" (1993:1-2).

To obtain subspecialty recognition, the requirements for which include a national organization to represent the field (i.e., AAAP) and specialized medical training programs (i.e., addiction psychiatry fellowships) (see American Board of Psychiatry and Neurology, Inc. 2006), Sheldon Miller "persuasively" presented to the American Board of Psychiatry and Neurology "a significant body of knowledge that was separate from, and more in depth than, a general psychiatrist would glean from their residency training in general psychiatry" (ABPNO-13). The comorbidity literature typified this knowledge which fellowship training programs disseminated. "The board's judgment," said an official with the American Board of Psychiatry and

Neurology, "was that … there were a number of [training] programs extant at that time that … were graduating a sufficient number of fellows … [and] that there was active research going on … related to these teaching programs" (ABPNO-13).[8] According to Marc Galanter, this assessment was "compatible with the considerable growth of medical training in addictions in recent years, particularly in departments of psychiatry" (1993:7).

By 1991, 48 addiction fellowships trained 122 fellows (Galanter and Burns 1993; Galanter, Kaufman, Schnoll, and Burns 1991). This surge in training since the late 1980s can be attributed to Galanter's extensive efforts on behalf of AAAP. Research grants from the National Institute of Mental Health and the scholarly and clinical contributions of prominent psychiatrists and AAAP officers like Richard Frances, Edgar P. Nace, Edward J. Khantzian, Richard N. Rosenthal, Robert B. Millman, and Stephen L. Dilts added to Miller's case for subspecialty recognition.[9]

One addiction psychiatry insider had a slightly different take on how the psychiatrists acquired board subspecialty status:

> It became a collegial activity…. They infiltrated [the American Board of Psychiatry and Neurology]…. What do psychiatrists do for a living? They manipulate relationships, they look at behavior, and they applied those interpersonal and power skills in a way to manipulate the system to get what they wanted. It [subspecialty recognition] was based on lock-stepping personal relationships with the decision-makers (APO-23).

The same year that Miller helped addiction psychiatry win board recognition, he also became a director of the American Board of Psychiatry and Neurology and later the Board's vice-president ("Miller to Join Accreditation Council" 2001). Halpern argues that occupational control depends on a professional group's institutional support, or its relationship with powerful and "established segments" of the broader profession (1992:1006). "Jurisdictional control involves two interdependent levels of professional relations; subordination on one level begins with collaboration at the other" (Halpern 1992:1015).[10]

In 1993, 475 psychiatrists passed the first subspecialty certification exam in addiction psychiatry (see Table 3 for more information). To sit for the exam, psychiatrists had to be board certified in general psychiatry and devote at least 25 percent of their clinical practice to addiction treatment (Galanter and Frances 1992). Five years later, with 1,776 board certified addiction psychiatrists, the American Board of Psychiatry and Neurology stipulated that all applicants for the subspecialty exam must complete a one year training fellowship that is approved by the Accreditation Council for Graduate Medical Education (see Galanter, Dermatis, and Calabrese 2002).[11]

"[T]he accrediting process … supports circumstances in which full-time careers of teaching can be created that in turn sustain a group within the profession that is in a position to serve as the authoritative repository of the basic stock of formal knowledge over which the profession claims jurisdiction" (Freidson 1986:82-83). Galanter described accredited fellowships as "essential in order to provide academic

teachers and consultants for both general psychiatrists and other professionals in the field, as well as expert researchers" (see Committee on Training and Education in Addiction Psychiatry 1996:852).[12]

What is more, although Galanter (1993) expressed concern that the new fellowship requirement might exclude otherwise qualified psychiatrists from entering the field, the requirement arguably sustained and even increased support for specialized training for psychiatrists and for addiction psychiatry itself.[13] To reiterate, psychiatrists overrepresented fellowship trainees because only departments of psychiatry offered fellowships. A new training requirement would not likely diminish the ranks of fellows who typically sought this instruction before it became mandatory. Therefore, compulsory fellowship training was simply a more formal step toward the board recognized subspecialty credential—and medical-professional status—to which it led. Moreover, that accredited fellowship training was required to achieve this credential now assured the survival of both. Addiction psychiatry could manage encroachment from other medical fields, particularly addiction medicine, by arguing that anything less than accredited fellowship training was not training enough.

The Accreditation Council for Graduate Medical Education currently recognizes 41 fellowships that lead to a board subspecialty in addiction psychiatry (see American Medical Association 2007). As Galanter stated 15 years ago, "postgraduate training in the treatment of addiction in the United States is provided primarily by academic psychiatry" (1993:1).

The Right to Responsibility for Addiction Treatment

Recognition for addiction psychiatry from the American Board of Psychiatry and Neurology reflected "psychiatrists taking care of themselves and trying to develop a subspecialty for and by psychiatrists. [They] wanted to 'up the ante,' raise the training, be more precise, more in-depth, [and] provide a true subspecialty for people in the specialty" (AM/AP-16). Board recognition also signaled the psychiatrists' discomfort with addiction medicine. As one treatment specialist explained, subspecialty recognition "gathered steam simply because there were a lot of psychiatrists working in the field who saw [addiction] as the proper turf or domain of psychiatry. But ASAM had all the thunder. And I think that many of the leaders in psychiatry who were very skilled in the treatment of addiction felt that the ASAM certification simply was not adequate" (AM/AP-22).

Two of these leaders characterized the ASAM certification exam as "made up by their own guild members" (AP-7) and "not that intense" (AP-9). "You take a review course and then you take the exam and that's it," said another addiction psychiatrist (AP-20). A former president of AAAP was more direct. "The [ASAM] certification exam is not enough. Addiction psychiatry 'added qualifications' require a year fellowship [training] before you can take the [addiction psychiatry] exam and, yes, that is enough. That's kind of the gold standard" (AP-8). Addiction medicine certification is "nonsense," declared a former addiction psychiatry official, because it is not a board certified credential:

> There is zero sanction behind [ASAM] certification. Nobody in organized medicine sanctioned it…. It is kind of like I set up my own certificate in tennis … and I have a good 'PR' machine to do it…. That is the view that will be expressed by those who got the subspecialty certification through the American Board of Psychiatry and Neurology which is organized medicine…. Organizationally, you can say ASAM … failed to … get … their board so they said, 'we'll [create] our own [certification], and we'll make it look like the rest of [the board certification exams]'…. But regardless of how you look at it, it is still their own certification, developed by them and monitored by them (APO-23).[14]

Conversely, addiction psychiatrists promote their medical knowledge and board recognized status. "With their greater understanding and training," argued one founder of AAAP, "[addiction psychiatrists] might be able to be the leading educators [and] … public policy people. They might be doing research [and] … heading up [treatment] programs [and] … at the forefront of the field … dealing with the more difficult situations that come up" (AP-7). Marc Galanter agreed: "psychiatrists should … be trained to assume leadership roles in proper management, education, and consultation with … diverse disciplines in relation to patients with substance-related disorders" (1996:852). In short, psychiatrists should be responsible for addiction treatment.

Board recognition for the psychiatrists, however, was stimulated by more than their leadership interests in the field and their concerns with the certification exam in

addiction medicine. The psychiatrists were motivated by more than the scientific literature on comorbidity, fellowship training programs, and their contention that "addictions are the most common of psychiatric illnesses" (Galanter 1989:8). In the 1980s and early 1990s, leading addiction psychiatrists insisted that recovering alcoholics and drug addicts permeated addiction medicine and ASAM, most of whom lacked specialized training in substance abuse and some of whom had not completed residency training in any medical specialty at all.

Psychiatrists were troubled by what physicians in recovery knew medically and scientifically about addiction and how they applied this knowledge to treatment. The psychiatrists questioned what recovering doctors in ASAM knew besides what they learned while getting sober in Alcoholics Anonymous, directing Minnesota Model treatment facilities, and reading *Principles of Addiction Medicine* (Graham, Schultz, Mayo-Smith, Ries, and Wilford 2003), ASAM's primary text and one of a handful of works which that organization advises candidates for its certification exam to review. That physicians in addiction recovery rated Alcoholics Anonymous more important to their sobriety than the professional treatment they received validated this concern (Galanter, Talbott, Gallegos, and Rubenstone 1990). As one respected treatment specialist said:

> These were people that were in the practice community, got into the field because of their own personal recoveries, [and] had never published a thing. And [addiction psychiatrists] viewed ASAM as being full of … non-intellectual, non-academic people. So they took some umbrage, if not offense,

> that so many people without academic legitimacy would be embraced [by organized medicine] (AM/AP-16).

One of addiction psychiatry's leaders said that "the problem with ASAM was that they were trying to legitimize people who were being pulled into the field more because of their own recovery than having had a scientific training or background in the field." He called ASAM a "haven" for physicians in recovery who were trained in non-clinical specialties with no relation to addiction such as dermatology, radiology, and pathology—"[their] main understanding of the disease came from their personal experience of having had the disease"(AP-7). According to a former president of AAAP:

> Both ASAM and the [impaired] physicians movement … were from recovering physicians. They tended to be wonderful people, dynamic people who had no training other than the fact that they had recovered [through] Twelve-Step. Part of our concern was that this organization, ASAM, and this body of physicians reflected knowledge of nothing but Twelve Step programs … [when] there is a whole additional body of knowledge (AP-20).

"People in ASAM call themselves 'addictionologists,' said a highly placed AAAP officer, "and that's people who are as far as I'm concerned undereducated. They may be very good at treating addictions … but those are people who don't have board certification and can't sit for board certification. So they'll give you a story, but that's probably the truth of the matter" (AP-14).

Addiction psychiatrists claimed that they could offer a service grounded in science and medical training that their non-psychiatric addiction medicine counterparts, especially those in recovery, could not. Board subspecialty recognition for addiction psychiatry was a formal endorsement of this claim that gave addiction psychiatrists considerable status and power in organized medicine and thus the "right to responsibility" (Goode 1960) for the medical treatment of addiction.

Table 3

Addiction Psychiatry Certification Exam Results 1993-2006*

Exam Year	Number of Examinees	Number of Psychiatrists Certified	Percentage of Psychiatrists Certified
1993	#	475	#
1993	#	302	#
1996	#	290	#
1997	#	278	#
1998**	#	431	#
2000	41	41	100
2002	44	37	84
2004	43	41	95
2006	70	64	91

*Source: Computer Testing Department, American Board of Psychiatry and Neurology, Inc.

**1998 was the last year that psychiatrists taking the addiction psychiatry certification exam were not required to complete one year of fellowship training, hence the rise in examinees compared to 1997 and the drop in examinees in 2000.

#No data available.

Notes

[1] Pioneer House opened in 1948 and was the first alcoholism treatment facility in Minnesota to base its two to three week residential treatment program on the Alcoholics Anonymous Twelve Step program of recovery. In 1949, Hazelden was founded as a farmhouse sanctuary for priests and professionals that incorporated the Twelve Steps into every aspect of a patient's three week stay. In the 1950s, the Minnesota Model coalesced at Willmar State Hospital, a former addiction treatment asylum that became a psychiatric institution. Willmar State Hospital promoted alcoholism as a primary disease that was healed by spirituality and the Twelve Steps in conjunction with physicians, clergy, social workers, and recovered alcoholics during a 60 day stay. See White, *Slaying the Dragon: The History of Addiction Treatment and Recovery in America* (1998).

[2] The Betty Ford Center and Sierra Tucson, two well-known addiction treatment centers that opened in 1982 and 1983, respectively, still incorporate components of the Minnesota Model in their treatment programs.

[3] White notes that "in the late 1980s and early 1990s, aggressive gatekeeping by managed-care companies and health-maintenance organizations dramatically eroded inpatient and residential treatment. Approved reimbursement for inpatient addiction treatment had dropped from 28 days to 18-21 days, to 14 days, to 5-7 days, and then to a few days of detoxification." See White (1998), 285. "As well it should have," commented one ASAM-certified psychiatrist (AM/P-18).

[4] "I was elected president of both groups at different times," Galanter writes about leading ASAM and AAAP, "but was always viewed with a degree of suspicion by many in the leadership in each one due to my affiliation with the other. There was always a conflict in being sympathetic to AA and being biomedically oriented as well." See Galanter, *Spirituality and the Healthy Mind: Science, Therapy, and the Need for Personal Meaning* (2005), 51.

[5] Unlike substance dependence, the diagnostic criteria for substance abuse do not include physical tolerance, withdrawal, or compulsive drug use. See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (2000), 191-199.

[6] For comorbidity research before the ECA study, see Crowley, Chesluk, Dilts, and Hart, "Drug and Alcohol Abuse Among Psychiatric Admissions: A Multidrug Clinical-Tosicologic Study" (1974); Hasin, Grant, and Endicott, "Lifetime Psychiatric Comorbidity in Hospitalized Alcoholics: Subject and Familial Correlates" (1988); Khantzian and Treece, "DSM-III Psychiatric Diagnosis of Narcotic Addicts" (1985); Lewis, Helzer, Cloninger, Croughan, and Whitman, "Psychiatric Diagnostic Predispositions to Alcoholism" (1982); Lewis, Lee, and Rice, "Association of Alcoholism with Antisocial Personality in Urban Men" (1985); Powell, Penick,

Othmer, Bingham, and Rice, "Prevalence of Additional Psychiatric Syndromes Among Male Alcoholics" (1982); Rounsaville, Weissman, Kleber, and Wilber, "Heterogeneity of Psychiatric Diagnosis in Treated Opiate Addicts" (1982); Weissman, Myers, and Harding, "Prevalence and Psychiatric Heterogeneity of Alcoholism in a United States Urban Community" (1980).

[7] The National Advisory Committee also developed the fellowship training standards for the Association for Medical Education and Research in Substance Abuse (AMERSA), the organization that co-founded the Center for Medical Fellowships with AAAP. AMERSA was founded in 1976 by physicians in the Career Teacher Program, a federal grant initiative for medical school faculty to develop and teach substance abuse curriculum in their home institution. AMERSA, whose first president was Marc Galanter, is a multidisciplinary organization of physicians and other health care professionals that I argue, for this reason, had no practical use for the fellowship training standards. AMERSA is an important voice for medical education on addiction, but the organization lacked the institutional authority in medical schools to integrate the fellowship training program outlined by the National Advisory Committee. For more information on AMERSA, see Samet, Galanter, Bridden, and Lewis, "Association for Medical Education and Research in Substance Abuse" (2006).

[8] "The attitude of the board at that time was that [it] should be responsive to the field," said the same official with the American Board of Psychiatry and Neurology. "It [subspecialty recognition] was not anything that [the] board wanted to do on its own or was pressing the field to come forth with" (ABPNO-13).

[9] Much of the early scholarship of leading addiction psychiatrists would be featured in the *American Journal on Addictions*, the official publication of AAAP since 1992. Sheldon Miller has served as this journal's editor since its inception.

[10] In 2001, Sheldon Miller sat on the Accreditation Council for Graduate Medical Education, presumably giving addiction psychiatry an added voice inside organized medicine's training and credentialing establishment. See "Miller to Join Accreditation Council" (2001).

[11] In 1996, the Accreditation Council for Graduate Medical Education formally approved one year addiction psychiatry fellowships for the first time. By 1999, the Council had approved 38 training programs. Fellows spent most of their time on clinical care while research-related activities ranged from 50 percent of a fellow's time to between 10 and 30 percent. To Marc Galanter, this indicated "that post-residency [i.e., fellowship] training would yield more effective academics in addiction." See Galanter, Dermatis, and Calabrese, "Residencies in Addiction Psychiatry: 1990 to 2000, A Decade of Progress" (2002), 197.

[12] Data from the National Comorbidity Survey, the first diagnostic psychiatric interview that examined addiction and mental illness based on data from a national

sample, strengthened Galanter's contention regarding the import of accredited fellowships in addiction psychiatry. See Kessler, "Lifetime and 12-Month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Study" (1994a); Kessler, "The National Comorbidity Survey of the United States" (1994b); Kessler, Nelson, McGonagle, Edlund, Frank, and Leaf, "The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization" (1996).

[13] One psychiatrist affected by the American Board of Psychiatry and Neurology's new fellowship training requirement said that "by the time I took my [psychiatry] boards and was notified that I passed them, I got busy and … suddenly recognized that I was past the deadline to apply to take the [addiction psychiatry] exam. I was eight days late and they [the American Board of Psychiatry and Neurology] wouldn't let me take it [without meeting the new fellowship requirement]" (AM/P-18).

[14] According to one founder of AAAP, even if addiction medicine did become a medical specialty, psychiatrists who studied and treated drug abuse "didn't want to have to leave psychiatry in order to be in a different specialty [with] a whole separate residency program…. What we believed was that we as psychiatrists should first train as psychiatrists and then subspecialize in addiction" (AP-7).

CHAPTER SIX

THE ART OF ADDICTION TREATMENT

It is not that I do not value scientific rigor, but such rigor encounters existential limitations. I … will try to provide definitions; but at times I suspect [they] may seem forced or ridiculous.

—Dr. George Vaillant (1982:144)

Subspecialty recognition from the American Board of Psychiatry and Neurology gave addiction psychiatrists the "right to responsibility" for the medical treatment of addiction. With the scientific literature on comorbidity, exclusive fellowship training programs, and their scholarly contributions to the field, leaders of the American Academy of Addiction Psychiatry such as Sheldon Miller, Richard Frances, and Marc Galanter convinced the American Board of Psychiatry and Neurology that addiction is a psychiatric problem which mental health experts were best equipped to treat. Subspecialty recognition distinguished addiction psychiatrists from ASAM physicians who wanted recognition for addiction medicine from the American Board of Medical Specialties. Passing a "guild" exam (AP-7) without specialized or accredited substance abuse training is not sufficient to treat addiction the psychiatrists said, especially for doctors recovering from drug abuse whose philosophy of care derives from their personal experience in Alcoholics Anonymous.

But what does board recognition say about how addiction psychiatrists approach addiction? What substantively distinguishes their medical knowledge and

treatment methods from addiction medicine physicians? According to one treatment professional, "in order to find out whether there was a real difference, … you'd have to do a study" (AM-5).

This chapter examines how addiction medicine physicians and addiction psychiatrists talk about and treat addiction. Keller (1993) maintains that description guides the structure and expression of scientific knowledge. To examine description is to "make sense of the successes of science in terms of the particular linguistic and material conventions that scientists have forged for their sorts of muddling through" (Keller 1993:181). Comparing how addiction medicine physicians and addiction psychiatrists define addiction and deliver care illustrates the "art" of addiction treatment. That doctors from both fields acknowledge the complexity of addiction yet criticize their counterparts' medical knowledge and treatment approach reflects the "occupational usages" of knowledge and not simply "technical expertise" (Freidson 1970:357).

Addiction: Conceptual and Methodological Accord

Accord at the Level of Conception

In 1992, ASAM and the National Council on Alcoholism and Drug Dependence (NCADD; formerly the National Council on Alcoholism) published a joint definition of alcoholism in the *Journal of the American Medical Association*. Psychiatrists Robert M. Morse and Daniel K. Flavin authored this definition, stating

that it was "(1) scientifically valid, (2) clinically useful, and (3) understandable by the general public" (1992:1012):

> Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic (1992:1013).

At the same time, addiction treatment entered what one neuroscientist called "the decade of the brain." During the 1990s, "brain mechanisms [had] … become a major focus of addiction research, and addiction research [had] … become a major focus of modern neuroscience" (Wise 2000:27). In 1999, for instance, Alan I. Leshner, director of the National Institute on Drug Abuse from 1994-2001, testified before the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources that "we now know more about abused drugs and the brain than is known about almost any other aspect of brain function" (1999). Addiction, Leshner stated, is a chronic disease triggered by the effect of compulsive drug abuse on the brain. Habitual drug use leads to tolerance, or a reduction of a drug's pleasurable effects that are regulated by a neurotransmitter (or chemical) in the brain called dopamine. In response, users ingest more drugs, thereby increasing dopamine levels so that the brain can recall the drug's original pharmacological results. When this pattern is repeated, Leshner wrote, "a metaphorical switch in the

brain seems to be thrown…. Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use" (Leshner 1997:46).

In 2001, ASAM (in conjunction with the American Academy of Pain Medicine and the American Pain Society) crafted a definition of addiction that borrowed from Morse and Flavin's description of alcoholism and the latest brain disease literature.[1] Appearing in *Principles of Addiction Medicine*, ASAM's main clinical text, the definition reads that addiction is "a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving" (Graham et al. 2003:1601-1602).

In this study, addiction medicine physicians echoed ASAM's definition of addiction, specifically that the condition is a brain disease. "Taking a drug on a regular basis … will change the way your brain behaves," said an ASAM-certified physician who believes that the central nervous system predisposes some people to addiction. "Once that change has taken place, your ability to control your intake of that drug begins to deteriorate and subsequently leaves altogether" (AM-5). A former president of ASAM called addiction a "brain disorder" that causes compulsive drug use. "It's probably genetically predetermined, but not necessarily so" (AM-2). One of the field's most vocal leaders agreed, saying that "addiction is a primary disease … always accompanied by denial.... If you abuse [drugs] and have a genetic template,

you will then get changes in the [brain] which will lead to compulsivity, which is the number one symptom of the disease" (AM-11). Summarizing these descriptions, an ASAM physician with 30 years of treatment experience argued that "chemical dependency is a chronic brain disease characterized by regular use of mind-altering drugs, continued use of those drugs in spite of adverse consequences or because of adverse consequences, increased use over time, withdrawal symptomatology whenever one cuts down or stops, and a tremendous compulsion to continue using" (AM-4).

The word "addiction" is not included in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), American psychiatry's official analytic text. Instead, the phrase "substance dependence" refers to "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior" (American Psychiatric Association 2000:192).

The diagnosis of substance dependence is based on experiencing at least three of seven clinical criteria in a one year period: (1) tolerance, (2) withdrawal, (3) heavy use over an extended time period, (4) uncontrolled use, (5) effort and time finding drugs, using them, and recuperating after use, and (6) reluctance to participate in normal life events. The seventh criterion of substance dependence tenuously ties drug use with mental illness: "the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is *likely*

[emphasis added] to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression)" (American Psychiatric Association 2000:197). The DSM-IV also lists "substance abuse" which, unlike "dependence," does not involve physical tolerance, withdrawal, and compulsive use (American Psychiatric Association 2000).

"Formally, I would define addiction the way dependency is defined in DSM-IV," said a nationally recognized addiction psychiatrist (AP-9). An ex-president of the American Academy of Addiction Psychiatry (AAAP) concurred: "addiction means that a person has acquired a dependency on a chemical [and is] pretty much defined in DSM-IV" (AP-8). Informally, however, psychiatrists described addiction the way ASAM doctors did, although the psychiatrists used the word "dependency." One of addiction psychiatry's founders stated that "addiction … usually involves such things as physiological dependence, tolerance, withdrawal, and also problems in work, family life, problems with stopping use, [and] compulsivity of use patterns" (AP-7). Another psychiatrist noted that "[addiction is an] overwhelming involvement with the acquisition and use of a drug and severe dependency on it. So that implies out of control use [which has] gotten significantly in the way of important aspects of life" (AP-9).

A former head of AAAP said that "addiction … means a person has acquired a dependency on a chemical that takes priority in their life in terms of how it shapes their thinking, their behavior, and their motivational effort. And their life begins to revolve around the addiction…. It's acquired by exposure to the substance … [and]

probably … interacting with a genetic factor as yet not well specified" (AP-8). A psychiatrist who has studied and treated substance abuse for almost 40 years stated that "addiction is the use and dependence of addictive substances to the extent that it begins to interfere in important aspects of an individual's life. [Addicts] use more than they intend to use [and] there are attempts to control their use, but they continue to use despite the adverse consequences" (AP-12).

One medical expert declared that terminology has left addiction medicine and addiction psychiatry in "a hell of a fix" (AM/AP-16). Physicians from both fields use words like "addiction," "substance dependence," "substance abuse," and "chemical dependency" interchangeably. A psychiatrist who uses the term substance dependence "until we find something better" explained how terminology impacts scientific research. "I think there is a lot of sloppiness in the literature. People will just off the top of their heads define addiction [as] … the compulsion to use, and that's certainly part of it but it doesn't capture the whole thing…. If I'm doing a study or writing something about addiction, I know exactly what I mean by addiction. I'm using the DSM-IV criteria. Period" (AP-8). Conceptual uncertainty, said a different addiction psychiatrist, is part of the job:

> I'll sit here … and tell you that the likelihood that anyone has … the psychiatrically defined disease of 'substance abuse' is almost zero. Of my patients, probably 95 percent … have dependence or addiction, and the other 5 percent have something else [but] none have '[substance] abuse.' Now on the other hand, if you speak to some of the other doctors, they may say, 'well

> most of my patients have [substance] abuse. I must be seeing a very different group of people than Dr. [X] is.' But probably they are not. Probably if we swapped places my percentages would be the same. It's just a matter of definition (AP-21).

A close look at ASAM's definition of addiction and the DSM-IV description of substance dependence reveals that both terms link the brain, behavior, and biology to chronic drug use. For the brain, ASAM chooses the term "neurobiological" while psychiatry uses "cognitive." To describe the development of behavior, addiction medicine refers to "psychosocial" and psychiatry simply to "behavioral." For addiction's biological component, ASAM uses the word "genetic" while psychiatry prefers "physiological." ASAM states that these "factors" lead to "craving" and "impaired control" despite "harm." Likewise, in the DSM-IV, the above "symptoms" lead to "withdrawal" and "compulsive use" despite "substance-related problems." Lastly, although a tie between chronic drug use and mental illness is one criterion for substance dependence, that diagnosis is not contingent on a psychiatric problem.[2]

Leading ASAM physicians and addiction psychiatrists also described the word "addiction" the same way. ASAM doctors argued that addiction is a genetically predetermined brain disease that leads to tolerance, withdrawal, uncontrollable drug use, and personal and professional problems. The addiction psychiatrists rarely used the terms "brain" and "disease" when they talked about drug "dependency," but they identified the same physiological symptoms and adverse physical and personal consequences of habitual drug use: tolerance, withdrawal, health problems, and

trouble at home and at work. One addiction expert concluded that "inside the world of psychiatry and inside the world of addiction medicine, I think there is considerable consensus about [addiction's] biological basis and so forth" (AM/AP-22). Psychiatrists and the DSM-IV have been "strongly influenced" by ASAM's definitions of alcoholism and addiction, said a doctor who straddles both fields, "although they would never acknowledge it" (AM/AP-19).[3]

Accord at the Level of Method

Addiction medicine physicians and addiction psychiatrists in this research agreed that drug treatment should be based on the clinical needs of each patient. The treatment methods to which these doctors most often referred, particularly the psychiatrists, included cognitive behavioral therapy, group therapy, self-help groups, pharmacological medications, and individual psychotherapy.[4]

Cognitive behavioral therapy modifies "surface-level" thoughts and "core beliefs" that are fundamental to addictive behavior (Beck, Liese, and Najavits 2005). "An important assumption is that substance abuse is in large part learned and can be modified by changing cognitive-behavioral processes" (Beck, Liese, and Najavits 2005:476). Physicians use cognitive therapy to evaluate their patient's motivation for change, substance-related views, and early life experiences with and without drugs. "Such exploration helps both clinicians and patients understand how patients came to such ridged, global, and inaccurate negative ideas about themselves" (Beck, Liese, and Najavits 2005:480). Cognitive therapy also helps patients develop coping strategies for environmental cues that might lead to relapse, and it is frequently

administered in conjunction with Twelve Step programs (Beck, Liese, and Najavits 2005).

"Group therapies … [create] a milieu in which members of a group can bond with each other, thus reducing the stigma associated with addiction and the humiliation of having lost control of one's own behavior" (Daley, Mercer, and Spotts 2003:839). Administered in residential treatment, therapeutic communities, or intensive outpatient programs, group therapy addresses aspects of recovery related to physical and mental health, lifestyle choices, and family and professional issues (Daley, Mercer, and Spotts 2003). Treatment peers encourage abstinence as group leaders who are physicians, therapists, or counselors facilitate. Group therapy differs from self-help programs such as Alcoholics Anonymous because self-disclosure is promoted, thus eliminating anonymity (Daley, Mercer, and Spotts 2003).

Self-help groups are the most widely used and accessible treatment resource (Galanter, Hayden, Castaneda, and Franco 2005; Substance Abuse and Mental Health Services Administration 2007). Alcoholics Anonymous is the "prototypical organization" of the self-help enterprise that includes Narcotics Anonymous, Cocaine Anonymous, and Gamblers Anonymous, all of which incorporate the Twelve Step program of recovery (Galanter, Hayden, Castaneda, and Franco 2005:511). Most physicians who treat addiction argue that "almost all patients afflicted with addictive disease will have a more rewarding recovery if they actively participate in a Twelve Step program" (Schulz 2003:953).

Pharmacological interventions serve a variety of treatment purposes (see Wilkins and Gorelick 2003). For example, methadone and buprenorphine are administered to opiate addicts as a type of "substitution therapy" because they are pharmacologically similar to opiates like heroin but less dangerous. Other medications like clonazepam for alcohol reduce the effects of drug withdrawal. Drugs like naltrexone and disulfiram (Antabuse) decrease substance use, relapse, or the intensity and duration of a substance's pleasurable effects while other medications are used for addicts with mental health disorders (McCance-Katz and Kosten 2005).

Finally, individual psychotherapy focuses on addiction and psychological problems. These problems include emotional "deficits and dysfunctions" (Dodes and Khantzian 2005:457) which affect self-esteem, personal behavior, and relationships with others. Psychotherapy is for patients "who have the capacity to be at least moderately introspective" (Dodes and Khantzian 2005:459). Psychotherapists manage mental issues that cause or contribute to drug abuse, focus on abstinence and relapse prevention, and monitor their patient's motivation to change (Rounsaville and Carroll 2003). Patients might simultaneously participate in a self-help program (Dodes and Khantzian 2005).

A former officer of ASAM who wants a pill that can "change the changes" in the addict's central nervous system is resigned to "work with what pharmacological agents we have and use cognitive behavior therapy…. Added to that [we] try to encourage people to go to self-help groups because … [addiction] is a chronic illness [and] and the medical system isn't going to pay for repeat episodes of cognitive

behavioral therapy" (AM-5). Another ASAM doctor follows a "multi-directional" treatment approach. "I do not argue with the principals of AA in which [addiction] is a psycho-social-physiological-spiritual disease," he said. "[But] is there more than one treatment? Yes. And now with some of the newer medications coming out and some of the newer techniques of looking at the brain, … I think there are definitely additional ways of treating [addiction]" (AM-2).

The most effective way to treat addiction is with a multidisciplinary team and a multidisciplinary approach, concluded a leading member of ASAM. "I'm obviously very opposed to looking at addiction without psychiatric input, but I'm also opposed to looking at [and] treating this disease … just through a psychiatric window" (AM-11). A colleague in addiction medicine concurred. "I think you have to approach everyone individually [because] everyone has different needs…. They come to you in different stages [of] this disease. Some of them have been using regularly and getting into trouble for 35 years, some of them maybe for two years, [and] some of them don't even know they have any trouble yet" (AM-4).

Similarly, a nationally recognized addiction psychiatrist said that "Twelve Step approaches are very helpful, [as are] cognitive behavioral approaches [and] psychodynamic approaches. So really trying to tailor the treatment to the patient in addition to the fact that we have some new psychopharmacological agents for different kinds of addiction" (AP-7). Another psychiatrist argued that the primary methods to treat addiction are "all good at different times for different people. There's a place for each of them" and for two or more simultaneously. "Treatment

programs should combine the models in interesting ways," he continued. "You need to deal with psychiatric [and] psychological personality factors and the Twelve Steps can be invaluable" (AP-9). An ex-president of AAAP noted that "we've got all of these different methodologies, … none of which is a slam dunk. There are [treatment] synergies, and where the synergies are you use all the tools available." This psychiatrist warned that some doctors treat all of their patients the same way. "That's terrible," he said. "Specificity is what makes treatment work. If I have a broken arm, I don't need insulin. One size fits all? Not! That's a bad idea" (AP-14).

Discord at the Level of Practice

According to one medical specialist, "if I gave you the names of the three addiction psychiatrists I know and respect most and the three addiction medicine doctors I know and respect most, I would say that there would be very little difference in that initial interview" (AM/AP-22). In other words, at the start of treatment, ASAM-certified physicians and addiction psychiatrists identify "the very basic issues of … your addiction history" (AP-12) and "there would be appropriate detoxification if necessary" (AM-2). After this initial work up, however, each group of physicians treats addiction differently.

<u>The Medical and Mental Aspects of Addiction</u>

One doctor stated that "the addiction psychiatrist just simply knows more psychiatry" (AM/AP-22) than a non-psychiatric ASAM physician. Another treatment expert explained:

> It's where the issues of comorbidities emerge that there is a distinction between an internist who is an addiction medicine specialist and a psychiatrist who is an addiction … specialist.... The internist would be more likely to have competence in treating the medical and physical comorbidities and psychiatrists would be more likely to have competence in treating the psychiatric and psychological comorbidities (AM/P-18).

One psychiatrist said that with an ASAM-certified internist "you [the addict] are going to … get a full physical exam. You'll be put on the table. You'll be prodded and poked. Bloods will be drawn. And there will be an approach that would have the perspective of whole body issues that are important. You'll talk about your liver. That's where things will start" (AP-21). In contrast, addiction psychiatrists prod and poke for behavioral and psychological issues. "'How are you feeling? What is your mood like? Do you get anxious? Do you find that it's difficult to be around other people?' You're not going to get undressed. You're not going to have your labs drawn" (AP-21).

Addiction psychiatrists "make a comprehensive list of psychiatric diagnoses that are present, the substance use disorder being one of them," concluded one specialist, "and addiction medicine physicians are interested in providing a list of all diagnoses and really looking at a variety of medical complications as well" (AM/AP-16). Addiction psychiatry is rooted in the "bio-psycho-social tradition" of human behavior, stated one of the field's most respected members. "It truly does honor … the psychodynamic traditions of understanding that human psychological problems

are not … chance happenings and developments. So it's rooted in the neuropsychiatric tradition." Conversely, "the people who are non-psychiatrists probably would be more inclined to keep [treatment] simple and to try and stick to the basics of getting the addiction under control" (AP-12).

An ASAM physician said that psychiatrists are less patient with addicts compared to addiction medicine doctors:

> [Psychiatrists] look at motivation more and willingness to change as barriers before they're willing to work with somebody. In medicine you have to see anyone that comes in. You don't get to say 'you're not motivated [to change] so I won't see you'.... I think that's kind of the main difference. In medicine, we're used to seeing people over and over for the same problem and we don't put them down because they can't change or do the things we want. We get frustrated with them, … but you try and help them as if it [addiction] [was] a health issue instead of … just a behavioral issue (AM-4).

An ASAM-certified addiction psychiatrist agreed. "I have a lot of concern that … the psychiatrists tend quickly to diagnose comorbidity and medicate whereas I think addiction medicine doctors are much more patient in terms of seeing how the individual looks sober" (AM/AP-22).

Comparing these differences to a "religious war," one psychiatrist argued that "there's a lot of ASAM-certified doctors who know a huge amount and who have … good skills, but … they don't know anything compared to [us] about

psychopharmacology … or diagnosing comorbid disorders" (AP-9). Another mental health expert acknowledged that ASAM physicians "probably" understand the psychiatric components of addiction better than "the average internist," but stopped short of saying that they know as much about comorbidity as board certified addiction psychiatrists. "We'll know a little bit more" (AP-7):

> So there's some concordance there, and some overlap, but there's also a distinction. The psychiatrist is going to know more about cognitive behavioral approaches to treatment. An ASAM person isn't going to use some cognitive behavioral approach to treatment, [and] they are not going to be anywhere near as sophisticated on the … psycho-social side as the psychiatrist. On the biological side, they may be more sophisticated (AP-7).

In fact, "addiction psychiatrists generally loathe to venture into the internal medicine or primary care world because of their own lack of training and liability issues," said a high-ranking ASAM officer. "So I think it's more likely that an addiction psychiatrist will consult to get the medical needs of their patient met than you'll see addiction medicine physicians consulting a psychiatrist" (AM/AP-16). An official from the American Board of Psychiatry and Neurology confirmed this:

> The medical aspects … of alcoholism or addiction—the treatment of infections and the treatment of medical complications—certainly is not the primary responsibility of psychiatry. We'd want to refer those patients … when they needed … critical medical care. There are some distinct

> differences between what a psychiatrist would do compared to what an internist or family doc or a pediatrician would do (ABPNO-13).

The Importance of Psychiatric Training

Addiction psychiatrists are all board certified general psychiatrists and thus trained to treat the mental health components of substance dependence. As a result, some leaders of AAAP conclude that they are better equipped to handle addiction than most ASAM-certified physicians. "[Addiction medicine] is really the practice of addiction treatment by doctors," stated one psychiatrist (AP-14). Consequently:

> Most of those guys are not all that sophisticated, but most of them are going to be up to date about medicine because if you're an internist or a family medicine doc you know about medication…. [But] that's where it stops. Physicians, other than psychiatric physicians, have no behavioral health training, which means they don't know anything about psychotherapy. They know nothing about development of the therapeutic alliance…. They don't know anything about cognitive behavioral therapy (AP-14).

"If you're talking about the knowledge set of psychiatrists," said a former AAAP president, "I would say definitely the knowledge set is different [than that of ASAM physicians]. I think you have a broader array of diagnostic approaches and treatment approaches that you're trained in" (AP-12). There are issues such as transference and countertransference, argued a founder of AAAP, "that psychiatrists are steeped in with understanding and internists usually [are not]." Furthermore, "the

emphasis on understanding the life story and history of a person in terms of what the family background is, the [family] network, [the] support system, … and how these things get applied in psychiatry are going to be at a different level than in most areas of medicine" (AP-7).

Stated differently by another psychiatrist, "if you go to an addiction medicine specialist, [he or she] may be able to do motivational enhancement, put you on [a] medication that may exist for that disorder, and do relatively well by [the] patient. What they're not going to be able to do is … psychotherapy" (AP-14):

> I am … going to do psychotherapy with them—looking at character change—to try to look at the vulnerabilities that they have to reduce vulnerability going forward so that they begin to become more adapted in the world as people who are emotionally fulfilled, professionally and interpersonally fulfilled.... [That] is what you do in psychotherapy so that the vulnerability to relapse is reduced over time (AP-14).

An ex-officer of AAAP agreed. "I think our subspecialty is built on a base of being able to do psychotherapy. And for non-psychiatrists, who are a majority of ASAM members, they're not trained in it…. They're not trained in it [and] they have little faith in it" (AP-20). This specialist claimed that psychotherapy is *the* difference between addiction medicine physicians and addiction psychiatrists.

"Synergy" is how another psychiatrist described his subspecialty's approach. "I have to know my internal medicine—the medical impact of the disease that my

patients have when I prescribe … an anti-drug abuse medication—as well as know how to do the psychiatric … interventions." Consequently:

> Some of the leadership of ASAM has been hostile to psychiatry, … and I think that has to do with ignorance and stigma and fear [because] they [have] got to know at some level that we know more than they do. We have a bigger palate. We paint with more brushes in more colors and we have a wider skill-set than they do. It's just that simple (AP-14).

An internist who has practiced addiction medicine since the early 1970s strongly disagreed. "I need to be a psychiatrist to give somebody methadone? I need to be a psychiatrist to treat overdose? I need to be a psychiatrist to detoxify people? I need to be a psychiatrist to understand cardiovascular damage done by high-dose cocaine" (AM-10)? Probably not, said one member of AAAP. However:

> I don't know any ASAM-certified [physician], whether he's an anesthesiologist, a retired obstetrician-gynecologist, or an internist that mustn't have had a lot of exposure to [psychiatric] comorbidity issues…. It would be malpractice almost. But maybe not. Maybe you're going to find out that there are some purebreds out there and they still insist it [addiction] is a disease (AP-12).

The Functions of Twelve-Step Treatment

Although AAAP psychiatrists in this research might believe they are better prepared than ASAM physicians to treat addiction, the psychiatrists do not discount

self-help programs like Alcoholics Anonymous, the mode of care they accuse addiction medicine physicians of using too often. We "cover all the bases," noted one psychiatrist who insisted that he and his colleagues design treatment plans that not only detox and consider comorbid conditions but also "respect and understand the Twelve-Step approach just as well as an addictionologist would…. [We] wouldn't disparage it [Twelve-Step treatment] or blow it off" (AP-8). Another psychiatrist argued that Twelve Step programs are as psychologically effective as cognitive behavioral and group therapeutic approaches. The "recovery culture," he said, is a powerful and positive influence:

> I say to my patients, 'look, I want you to go to the hospital … and see if you can get beyond the four or five day detox and get some longer stay either in the ongoing residential program or the day treatment program so that you can get introduced to the 'recovery culture.' [That] is the AA tradition. They [addicts] have to have the safety net. I can't provide them [a] '24/7' safety net, but that tradition can. And so it's not only practical [and] useful, but it's a very germane paradigm. I think AA works because it's an extraordinarily sophisticated group psychological approach…. So I'm not in any great competition with that (AP-12).

Neither is an addiction psychiatrist who tried to convince one of his patients to attend Alcoholics Anonymous meetings:

> I said, 'how often do you go to AA meetings?' and she said, 'I don't. I'm very uncomfortable sharing things about myself.' And I said, 'well of course

> you are, that's the disease. Anybody who said they felt perfectly comfortable with that would gain nothing from it because they don't have the illness. So the only reason why you have to do it is because you don't want to go.' The purpose of those meetings is not to stop you from drinking. The purpose of the meetings is to make it so you learn how to interrelate with others so that you have a way of relieving the tension and the stress and the anxiety that is a normal part of the human condition. And that's the cure. It [Alcoholics Anonymous] doesn't get rid of the fact that you have a chronic illness, but it certainly makes it so that now you can deal and cope with it (AP-21).

An ASAM-certified addiction psychiatrist concurred. "I happen to believe that, by far, the most effective program for maintaining abstinence from chemicals is the Twelve-Step approach. I strongly encourage all my patients to attend Alcoholics Anonymous or Narcotics Anonymous or another variation on the theme" (AM/AP-17). "I can tell you that if I were stuck with only one treatment," said a former president of AAAP, "it would be Twelve-Step" (AP-20).

Although top AAAP psychiatrists endorsed self-help programs, they do so, they said, having selected from a number of treatment methods they are trained to administer. In other words, according to one psychiatrist, "they need not have such a profound belief system" (AP-9):

> ASAM is much more … dominated by recovering people who really know a lot and … who often can relate to the profound spiritual issues that exist in people who are doing drugs and who are attempting recovery. [In contrast,]

> the psychiatrists can look at a bunch of modalities, including the Twelve Steps, and recognize the appropriateness of all of them.... I think in some ways ASAM is more based on the Twelve Steps and sees the other [methods] as more peripheral, though it's changing (AP-9).

An officer in AAAP agreed that addiction medicine is more "medical" and "scientific" compared to years past:

> I basically stopped being active [in ASAM] 10 or 12 years ago because I found a lot of [addiction medicine] hokey and backwards and not scientifically significant. They've made great strides over the last 10 years to become medically and scientifically sophisticated and now they are really up with the biology of addiction and they weren't 10 years ago. They were just Twelve-Step oriented, faith-based, [and had a] 'go to [AA] meetings and don't drink' attitude. Now they … understand that there are [brain] reward centers … [and] medications that affect motivation…. So I think the field is changing and I think it's much more convergent (AP-14).

Addiction psychiatrists granted that Twelve-Step treatment in addiction medicine has declined over the years: "you might not see [it] as much today as you did 15 [or] 20 years ago" (AP-8). However, the psychiatrists still identified addiction medicine with the self-help approach. One of them divided ASAM physicians into two groups. The first group advocates "nothing else but the Twelve Step program, and you better join that church and follow it to the letter of the law. And that's their 'shtick.'" The second group is "very tuned in to detoxification, maybe even some

medications for addiction, and maybe a little counseling, but they'll still be very Twelve-Step oriented" (AP-8).

The Twelve Step "mentality" in ASAM and addiction medicine is still "hugely, hugely pervasive," claimed another addiction psychiatrist. As a result:

> You get a lot of people with a lot of attitude who sound like a bunch of jerks these days because what they're saying isn't 'evidence-based.' It's belief based—'it's my way or the highway [and] this is the only way to recover.' A lot of those people can't think of the possibility of somebody recovering without Twelve-Step, without AA. And that's ridiculous (AP-14).

This psychiatrist sends "the bulk" of his patients to Alcoholics Anonymous. "But do I think one size fits all? It's like a religion. It's like 'there but through me you're not going to get to God.' Excuse me. I think that is presumptuous, arrogant, and plainly wrong. There are people who get sobriety without doing that. It's a new world" (AP-14).

An ex-president of ASAM, himself a recovering addict, noted that "everything I say is factually and evidence-based because I've been the brunt of [this type of criticism]" (AM-15). This doctor acknowledged, however, that ASAM physicians in recovery, particularly in the 1970s and 1980s, treated addicts based on their personal experience and not evidence-based medicine—the "new paradigm for medical practice" (Evidence-Based Medicine Working Group 1992:2420) that requires "the conscientious, explicit, and judicious use of current best evidence in making decisions

about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes, and Richardson 1996:71).[5] In short, "they [physicians in addiction recovery] didn't shift gears" (AM-15):

> I think some of the early leadership [of ASAM] would tend to use the same tactic that worked with the recovery community…. [But] you don't use the same approach. You don't get up in front of a medical group and say, 'Hi I'm Bill, recovering addict and alcoholic.' You say, 'I'm Doctor whoever. Addiction is a disease. Here's the science. Here's the data. Here's the outcome.' I saw in the early days some of the old-timers, particularly the AA old-timers, present to a medical audience the same way they would present to … the recovery community. It doesn't work.... In God we trust, everybody else has to have data (AM-15).

One addiction psychiatrist insisted that evidence-based studies funded by the National Institute on Alcohol Abuse and Alcoholism like Project MATCH and Project COMBINE "[show] very clearly what we know and what's available from within the research paradigm" (AP-14). Project MATCH sampled 2,000 alcohol dependent persons to compare—or "match"—Twelve-Step facilitation, cognitive behavioral coping skills therapy, and motivational enhancement therapy[6] with "client attributes" such as alcohol use, cognitive impairment, gender, life goals, motivation, mental health, and drinking interest. Project MATCH found that Twelve-Step facilitation was more effective than cognitive behavioral therapy if alcohol dependent

persons did not suffer from other psychiatric problems. This effect dissipated as a patient's mental health issues worsened (Project MATCH Research Group 1997).

Project COMBINE compared the medications naltrexone and acamprosate with therapy from a behavioral health specialist "to determine if improvements in treatment outcome for alcohol dependence can be achieved by combining pharmacotherapy and behavioral interventions" (The COMBINE Study Research Group 2003b:1107). Naltrexone and behavioral intervention reduced alcohol consumption. Acamprosate, despite its "proven" value in other studies, was ineffective. Project COMBINE also showed a "positive effect" for patients who received placebo medication in conjunction with counseling from health care professionals about treatment adherence and the negative effects of drinking. Altogether, "medical management of alcohol dependence with naltrexone appears to be feasible and, if implemented in primary, and other, health care settings, could greatly extend patient access to effective treatment" (The COMBINE Study Research Group 2006:2015).[7]

The former ASAM president and recovering alcoholic from above who embraces evidence-based medicine warned his colleagues about the unintended consequences of this paradigm:

> The [concern] is that it [evidence-based medicine] will … cut off the root of recovery [in addiction medicine] because a recovering physician will always be there.... Nobody else would take care of the addict and alcoholic and the recovering physician was there…. As we shift more to what's evidence-

> based, we don't [want to] forget our history and go so far in the opposite direction [that] we cut them off (AM-15).[8]

One addiction psychiatrist recovering from alcoholism considers his personal history of addiction as valuable therapeutically as evidence-based medicine. "I hold my status as a recovering individual as a very important part of my life. I'm one of those people who will say it's a way of life…. [But] I'm not an ideologue about it. I don't insist that everyone I see go to AA or do it the way I did it. But I am quick to share my own experience." This physician attributed contempt for his "therapeutic use of self" to his contemporaries' fixation on evidence-based medicine:

> My colleagues, particularly in psychiatry, have this thinly veiled antagonism. These are the same folks who won't really seriously look at a question unless they can use the new language of 'evidence-based research.' And there is a malignant side to that. There is an intellectual … arrogance in that that's just really sad. They don't know what they don't know (AM/AP-22).

Personal recovery is not essential to treat addiction, this psychiatrist with 20 years of experience argued, but it can be a valuable experience to utilize so long as physicians in recovery are not blinded by it. "Who we are is so inseparable from our transactions from others. This bears on … the philosophy of knowing, epistemology. Anyone who has really seriously looked at how therapy works has to be curious about epistemology … and the nature of the self…. My colleagues who have no interest in that, who dismiss that, are … just ignorant of those questions" (AM/AP-22).

Medical Knowledge and Occupational Interests

ASAM's definition of "addiction" and DSM-IV "substance dependence" both link the brain, behavior, and biology to chronic drug use. Moreover, like the ASAM physicians and addiction psychiatrists who use them, both terms identify tolerance, withdrawal, uncontrollable use, and adverse personal and professional consequences associated with drug abuse. Addiction experts in this study also agreed that treatment should be based on the individual needs of each patient and that it can include behavioral therapies, medications, and self-help groups like Alcoholics Anonymous.

At the level of practice, ASAM-certified physicians stressed the medical complications of addiction such as liver disease while the psychiatrists emphasized behavioral and psychological problems. Furthermore, although members of AAAP recommended Alcoholics Anonymous and conceded that addiction medicine has matured medically and scientifically to address psychiatric comorbidity, they also argued that the Twelve-Step "mentality" of ASAM overshadows evidence-based practice from "the research paradigm" (AP-14). There is room for both approaches said physicians in recovery.

The medical treatment of addiction is complicated, as one psychiatrist explained:

> Unfortunately, there's a great deal of art in this game. The so-called 'evidence-based studies' are to some degree nonsense. Often you're taking a shot at [treatment] based on your intuition, but you don't even know if you're

> right because the outcome studies are so difficult to do, so expensive, and so lacking. So the best that you can do is try to ensure that … your [treatment] process is based reasonably on accepted ideas that seem to make sense (AP-9).

Project MATCH, for instance, found that Twelve-Step facilitation is effective for alcohol-dependent persons without additional mental problems. Overall, however, "except for psychiatric severity, there [was] not convincing evidence of major treatment matching effects" (Project MATCH Research Group 1997:23). Project COMBINE demonstrated that naltrexone, behavioral therapy, and assistance from health care professionals "appears to be feasible" for alcohol dependence, but not for all alcoholics (The COMBINE Study Research Group 2006:2015). "So there is some art here," concluded the psychiatrist above. "There is some art and there is some science" (AP-9).

One ASAM physician compared the medical profession's knowledge about addiction to its knowledge about heart disease and infectious disease:

> We know what causes a heart attack. We know the mechanics of everything. But when you get right down to it, we don't know…. I believe to talk about a cure [for addiction] in the way that we found … [cures for] infectious diseases, I think we're a long way from that. But I think we'll keep describing it and characterizing it, but I doubt that there's going to be a single answer to all of this (AM-11).

The National Institute on Drug Abuse promotes addiction as a brain disease, noted one mental health clinician, "and that implies that you need scanning, medicine, and psychiatrists. But the truth is scanning hasn't shown anything in psychiatry except pretty pictures. I'm saying [this] from the inside, but we sure need a lot more development to make this the equivalent of, say, diabetes" (AP-9).

"I think we're dealing with the fact that a lot of medicine is a combination of science and craft, and that's especially true in addiction psychiatry," acknowledged one of the founders of AAAP. "A lot of things aren't that well researched out and a lot of people do things on the basis of the way they were trained and what their experience was" (AP-7). This assessment pertains to ASAM's definition of addiction as well as DSM-IV substance dependence. "These are evolving concepts, nothing is written in stone, and I had something to do with helping write and consult on the DSM-IV…. So not everything is absolutely crystal clear [or] scientifically proven" (AP-7). A former president of ASAM concurred. "I give groups … to patients and they always ask me what chemical dependency is. [I] show them three circles: all the people in America who don't use, all the people who use [or have used] occasionally, … and other people who use and get a disease. People really can get that. I wonder, sometimes, whether we in medicine get it" (AM-4).

"We like to pretend that everything … is very pure," said an addiction medicine physician, "like … the surgeon steps in [and] removes the problem organ. But most of medicine is not that" (AM-6). Likewise, "[psychiatry] … is trying to be like surgeons where you do a certain approach to the surgery. It's wanting to hang

your hat on a technologic treatment whereas psychiatry is not so skilled yet" (AP-9). All medical professionals who treat addicts are affected by these limitations:

> The people in the field are working with really hard problems, and so you've got to tip your hat to them. But for them to think that they've 'got it'…. I think we're still at the level of humors, as in [second century Greek physician] Galen…. The truth is we know a lot about medicines. We know a lot about diagnosis. We know a lot about comorbids. We've learned well and worked with the Twelve Steps. We understand the necessity to worry about the way people relay in the world. We're learning (AP-9).

If addiction medicine physicians and addiction psychiatrists are still learning, why do they criticize each other's medical knowledge in the first place? ASAM doctors argued that the psychiatrists are too focused on psychological comorbidity and behavioral issues to become comfortable treating the physical complications of addiction. ASAM physicians suggested that their approach to care, one that considers a patient's medical and emotional needs, is equally if not more effective for addicts than what the psychiatrists offer. Conversely, the psychiatrists claimed that ASAM physicians are still too Twelve-Step oriented and not trained to handle the mental health components of substance abuse nor administer psychotherapy and other critical behavioral interventions. To preserve their "right to responsibility" for treatment and medical status as the only board recognized subspecialists in the addictions, the psychiatrists have maintained that their professional training and scientific knowledge match the medical realities—the "evidence"—of addiction and mental health.

Freidson writes that "the knowledge of [a] profession is distinct from the circumstances and conditions in which it is applied, and … while the former may in most cases be said to be the best of our time, … the latter is neither codified, systematic, nor objective, reflecting the social position and occupational usages of the profession rather than some special technical expertise deserving of autonomy" (1970:357). Addiction medicine physicians and addiction psychiatrists criticize each other to defend not only their "technical expertise" but also their overlapping occupational interests. These interests range from the power to influence how the public and medical policy-makers understand addiction (see Galanter, Keller, Dermatis, and Egelko 2001), to access to patients and fees for services (see Lewis 2001; Stone 1997), to, in the context of this discussion, how drug abuse is conceptualized and treated in the medical community.

A final example should clarify. According to one addiction specialist, nationally recognized Twelve Step facilities like the Betty Ford Center traditionally underestimate psychiatric comorbidity. In contrast, prominent research institutes such as the Center for Studies of Addiction at the University of Pennsylvania overestimate the connection between addiction and psychological problems. "If [comorbidity] is only 5 percent, an ASAM doctor is just as good as everybody else. If it is 90 percent, then you really would like someone to know a little more about psychiatric diagnosis and about psychopharmacology. It turns out that the answer is probably in the middle, and both groups are exaggerating because of their own parochial view" (AP-9). A top addiction medicine physician explained why. "We don't have the answers, but there is a lot of *strong feeling* [emphasis added].

Certainly a month doesn't go by [that] I don't hear about, or somebody wants to tell me about, the magic bullet that is going to change all this, … [but] the answer is we don't know" (AM-11). The actions of a profession reveal its goals just as knowledge and method reveal human desire (Freidson 1986; Burrage, 1988 as cited in Macdonald 1995).

Notes

[1] For other studies that describe addiction as a brain disease, see Childress, Mozley, McElgin, Fitzgerald, Reivich, and O'Brien, "Limbic Activation During Cue-Induced Cocaine Craving" (1999); DuPont, "Addiction: A New Paradigm" (1998); Gordis, "The Neurobiology of Alcohol Abuse and Alcoholism: Building Knowledge, Creating Hope" (1998); Koob, "Neurobiology of Addiction: Toward the Development of New Therapies" (2000); Koob, Sanna, and Bloom, "Neuroscience of Addiction" (1998); Kosten, "Addiction is a Brain Disease" (1998); Leshner, "Drug Addiction Research: Moving Toward the 21st Century" (1998); Leshner and Koob, "Drugs of Abuse and the Brain" (1999); Nestler, "Psychogenomics: Opportunities for Understanding Addiction" (2001); Nestler and Malenka, "The Addicted Brain" (2004); Vetulani, "Drug Addiction. Part II. Neurobiology of Addiction" (2001); Volkow and Fowler, "Addiction, a Disease of Compulsion and Drive: Involvement of the Orbitofrontal Cortex" (2000); Volkow and Li, "Drugs and Alcohol: Treating and Preventing Abuse, Addiction and their Medical Consequences" (2005); Volkow, Wang, Fowler, Hitzemann, Angrist, Gatley, Logan, Ding, and Pappas, "Association of Methylphenidate-Induced Craving With Changes in Right Striato-orbitofrontal Metabolism in Cocaine Abusers: Implications in Addiction" (1999); Wise, "Drug-Activation of Brain Reward Pathways" (1998).

[2] Mental health issues that might relate to substance use are addressed in other parts of the DSM-IV manual. "Substance use is often a component of the presentation of symptoms of mental disorders. When the symptoms are judged to be a direct physiological consequence of a substance, a Substance-Induced Disorder is diagnosed. Substance-Related Disorders are also commonly comorbid with, and complicate the course and treatment of, many mental disorders." See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (2000), 204. However, that a diagnosis of substance dependence is not contingent on having a mental disorder underscores the similarity between ASAM's definition of addiction and DSM-IV substance dependence.

[3] Physicians who are certified in both addiction medicine and addiction psychiatry also described addiction using ASAM's terminology. "Addiction is a primary, chronic, and progressive disease process that has some genetic and some environmental and some social elements that contribute to its origins and its development," said one of these doctors. "It is primarily [a] disorder of … the [brain's] reward system, … [and] once it develops in an individual they are going to be dealing with it … for the rest of their lives" (AM/AP-17). Another ASAM-certified addiction psychiatrist said that "addiction is a chronic, primary disease … that … affects some areas of the [brain's] limbic system that are just beginning to be identified" (AM/AP-19). Addiction is a "biological and/or psychological dependency on chemicals that alters mood or thought," said a doctor certified in both fields, "[and a] brain disorder that [is] very poorly understood compared to where we'll be in 10 or 20 years" (AM/AP-22).

[4] This synopsis of treatment methods is intended to introduce readers to common forms of care according to the physicians who use them. Two edited volumes were especially helpful in this regard: Frances, Miller, and Mack, *Clinical Textbook of Addictive Disorders* (2005); Graham, Schultz, Mayo-Smith, Ries, and Wilford, *Principles of Addiction Medicine* (2003).

[5] The term "evidence-based medicine" was invented in 1992 by the Evidence-Based Medicine Working Group, a gathering of physicians, including David L. Sackett, the "father of evidence-based medicine," mostly from the Departments of Medicine and Clinical Epidemiology and Biostatistics at McMaster University in Ontario, Canada. See Mykhalovskiy and Weir, "The Problem of Evidence-Based Medicine: Directions for Social Science" (2004). "Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathopsysiologic rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research." See Evidence-Based Medicine Working Group, "Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine" (1992), 2420. This paradigm currently penetrates almost every corner of medicine, not just the medical treatment of addiction. For analyses and critiques of evidence-based medicine, see Armstrong, "Clinical Sense and Clinical Science" (1977); Armstrong, "Clinical Autonomy, Individual and Collective: The Problem of Changing Doctors' Behavior" (2002); Epstein, "The Outcomes Movement: Will It Get Us Where We Want To Go?" (1990); Fox, "Medical Uncertainty Revisited" (2000); Kassirer, "Clinical Problem-Solving—A New Feature in the Journal" (1992); Mykhalovskiy and Weir (2004); Timmermans and Angell, "Evidence-Based Medicine, Clinical Uncertainty, and Learning to Doctor" (2001); Timmermans and Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care* (2003).

[6] Motivational enhancement therapy helps addicts take responsibility for their substance use and for the personal changes required for recovery. See Beck, Liese, and Najavits, "Cognitive Therapy" (2005).

[7] For more information about Project MATCH and Project COMBINE, see Project MATCH Research Group, "Project MATCH: Rationale and Methods for a Multisite Clinical Trial Matching Patients to Alcoholism Treatment" (1993); Project MATCH Research Group, "Matching Alcoholism Treatments to Client Heterogeneity: Project MATCH Three-Year Drinking Outcomes" (1998a); Project MATCH Research Group, "Matching Alcoholism Treatments to Client Heterogeneity: Treatment Main Effects and Matching Effects on Drinking during Treatment" (1998b); Swift and Pettinati, "Choosing Pharmacotherapies for the COMBINE Study—Process and Procedures: An Investigational Approach to Combination Pharmacotherapy for the Treatment of Alcohol Dependence" (2005); The COMBINE Study Research Group, "Testing Combined Pharmacotherapies and Behavioral Interventions for Alcohol Dependence (The COMBINE Study): A Pilot Feasibility Study" (2003a).

[8] Physicians outside the addictions field have also cautioned against evidence-based research. Arnold M. Epstein of Harvard Medical School has written that clinical guidelines based strictly on scientific evidence are just one route to better medicine, not the only route. "Our expectations must be moderate if we are to avoid disappointment. The danger we face is that we will undermine a healthy evolution and allow revolutionary zeal to lead us to carry a good thing too fast and too far." See Epstein (1990), 269. Jerome P. Kassirer, a former editor-in-chief of the *New England Journal of Medicine*, argues in favor of consulting clinical trials research. However, Kassirer insists that medical care should not be based on this research but rather grounded in it. Published medical reports are too structured and fixed to address the "haze of uncertainty" of everyday medicine. For Kassirer, "the art of medicine involves interpolating between data points, selecting the data that match the patient most closely, and—by weighing the benefits and risks of available tests and treatments—recommending optimal choices." See Kassirer (1992), 60.

CONCLUSION

[I]t becomes the task of the sociological history of thought to analyse without regard for party biases all the factors in the actually existing social situation which may influence thought. This sociologically oriented history of ideas is destined to provide modern men with a revised view of the whole historical process.

—Mannheim ([1936] 1985:78)

"Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it" (Conrad 1992:211). After problems become medicalized, however, not all physicians agree on how to "treat" them. Conflict occurs inside professions, particularly in medicine, where specialty development causes competition between medical disciplines which share the same "turf" (Goode 1960; Jordan 1985). When conflict persists, the outcome determines which discipline "owns" the medical problem and its ability to control encroachment from competitors (Gusfield 1981).

This dissertation examines the competition between addiction medicine and addiction psychiatry to own the medical treatment of addiction. Central to this competition has been addiction medicine physicians who themselves are recovering addicts. They are what one interview respondent called the "beating heart that keeps [addiction medicine] going" (AMO-1). A group of academic psychiatrists argued that their understanding of drug abuse was superior to addiction medicine physicians and

doctors in recovery. The psychiatrists won responsibility for the medical treatment of addiction on classic medical and professional grounds: scientific knowledge.

Beginning in the early 1950s, a number of physicians in Alcoholics Anonymous (AA) joined other doctors in the New York City Medical Society on Alcoholism to promote the concept of chronic drunkenness as an illness that the alcoholism movement invented. Dr. Ruth Fox, whose husband died an alcoholic, and Marty Mann, a recovering alcoholic and public relations expert, organized these physicians. At the time, options for addiction treatment other than AA's Twelve Step program were scarce, and many New York Society physicians objected to the psychoanalytic approach that diagnosed alcoholism as a symptom of a mental problem and not a primary disease. "Freud himself could not have analyzed the drunk brain," one of these physicians said. "It wouldn't have worked" (AM-6). Doctors in recovery in the New York Society were especially loyal to the Twelve Steps, some of whom personally experienced psychoanalytic treatment and then turned to AA for care.

Nationwide, other physicians in recovery also dedicated their medical careers to addiction medicine. In the 1970s, during American medicine's impaired physician movement, G. Douglas Talbott started a series of treatment programs for addicted physicians, many of whom went on to establish their own treatment programs based on the same Twelve-Step model they used to recover. Talbott called these doctors "addictionologists." Given the shortage of medical care for addiction and the unique

insights of physicians in recovery, Talbott wanted the American Board of Medical Specialties to recognize “addictionology” as a medical specialty.

In the mid-1980s, after the field of addiction medicine unified under the American Medical Society on Alcoholism and Other Drug Dependencies, recovering addictionologists accounted for approximately one-third of all addiction medicine physicians. The certification exam in addiction medicine attracted hundreds more physicians to the field, including doctors in recovery. Physicians whose medical training was interrupted by substance abuse not only wanted a medical credential in addiction medicine but also recognition from the American Board of Medical Specialties. But addiction medicine failed to acquire board recognition, in part because the field lacked the training programs and institutional resources that only board recognition can provide. In 1990, one year after the American Society of Addiction Medicine (ASAM) formed, the American Medical Association classified addiction medicine as a “self-designated medical specialty.” This distinction did not professionalize or codify the medical knowledge of addiction medicine physicians, especially the medical knowledge of doctors in recovery.

Physicians who treat the same medical problem question what each other know and how they know it. Psychiatrists in the American Psychiatric Association who studied and treated addiction felt marginalized by addiction medicine physicians, mainly recovering addictionologists, whose medical knowledge about drug abuse, the psychiatrists insisted, stemmed from their personal loyalty to AA’s Twelve Step program. Led by Drs. Richard Frances and Sheldon I. Miller, these psychiatrists

founded the American Academy of Addiction Psychiatry (AAAP). They argued that addiction was a mental illness which was psychiatry's responsibility to treat. Leading addiction psychiatrists were especially concerned that addiction medicine might become board recognized. The psychiatrists pointed out that the certification exam in addiction medicine was based on ASAM's internal measures and not the scientific standards of the American Board of Medical Specialties. According to one treatment specialist, "[AAAP] was founded by academic psychiatrists … [who] … wanted to move away from ASAM which they considered to be nonacademic" (AM/AP-16).

In 1991, addiction psychiatrists convinced the American Board of Psychiatry and Neurology that they possessed a specialized "knowledge system" (Abbott 1988:30) on addiction that was embodied by their scholarly work, the comorbidity literature, and, ultimately, accredited fellowship training programs for a new generation of addiction psychiatrists. Occupational status is a correlate of formal knowledge. "The more one's professional work employs that knowledge alone—the more it excludes extraneous factors—the more one enjoys high status" (Abbott 1988:118). With board subspecialty recognition, the psychiatrists emphasized their relationship with formal knowledge while calling attention to what they regarded as the "extraneous factor"—knowledge about addiction based on the personal experience of recovering from addiction—that diminished the professional legitimacy and medical status of addiction medicine. One former addiction medicine official described these events as "galling" (AMO-1). However, "insofar as [knowledge] is accepted it constitutes the source of ownership of a problem" (Gusfield 1989:433).

ASAM still actively seeks recognition for addiction medicine from the American Board of Medical Specialties (see American Society of Addiction Medicine N.d.-a). It also bears repeating that presently about one-third of ASAM's estimated 3,000 members are in recovery from addiction[1] and that ASAM does not require its physicians to endorse AA's Twelve Step program. Still, the tradition of recovery in addiction medicine stigmatizes the field. Gusfield writes that "the division between the clientele and the professional is perhaps too finite. As the case of alcoholism suggests, … stigmatized groups and the problem-solving professionals contain significant components of persons who are, or have been, members of the stigmatized clientele" (1996:191). A psychiatrist with strong loyalties to ASAM explains:

> Is ASAM a bunch of drunks more worried about their own ability to get back into the workplace than anything else, or is it a bunch of doctors who have a fundamental understanding of this disease [addiction], sometimes based in personal experience? I prefer the latter. I think that this is a group of people, probably a good percentage of whom are in recovery, where that degree of personal knowledge adds to the overall understanding of the group as a whole. But does that cause stigma for all the organization? Yes, it does (AP-21).

Leading addiction psychiatrists currently acknowledge a "maturation process" (AP-14) in addiction medicine that continues to elevate the field's medical credibility. However, they still associate addiction medicine with the tradition of personal recovery that the field was founded on, that ASAM embraced when it united with the American Academy of Addictionology and the California Society for the Treatment

of Alcoholism and Other Drug Dependencies, and that addiction medicine has continued to attract (e.g., the alternate pathway to certification). The psychiatrists charge that physicians in recovery make "a profession of their stigma" (Goffman [1963] 1986:27), or as one prominent member of AAAP said, that there is still a "nudge-nudge-wink-wink" in addiction medicine about personal recovery and Twelve-Step treatment. "There is a real arrogance that I have seen among [ASAM] people and they look askance at people who are not part of 'the club'" (AP-14).

Addiction medicine doctors without drug problems are "the 'wise,' namely, persons who are normal but whose special situation has made them intimately privy to the secret life of the stigmatized individual … and who find themselves accorded a measure … of courtesy membership in the clan" (Goffman [1963] 1986:28). An ASAM-certified addiction psychiatrist, for example, said that "I'm probably viewed more by the addiction medicine people as an expert in the field than I am by my colleagues in psychiatry … [because] I had the great fortune of being appointed to the General Service Board of Alcoholics Anonymous…. Being on the board of AA … immediately opens a friendship with any doctor who is in recovery" (AM/AP-19). According to a former addiction psychiatry official, "the key difference" between addiction medicine and addiction psychiatry, "the one that causes the most fights and the most sitting on opposite sides of the issue, is the influence of the recovering community. ASAM is driven by that" (APO-23).

Stigma and competition, however, conceal the realities of medicine (see Goode 1960). Chapter Five on the development of addiction psychiatry explained

that as early as 1986, a year after Frances and Miller founded AAAP, 86 percent of psychiatrists interested in addiction supported Twelve-Step care (Miller and Frances 1986). As Chapter Six on the art of addiction treatment revealed, mental health experts believe that addicts are more likely to stay sober if they join a Twelve Step group no matter what medical or psychiatric treatments they receive (see Beck, Liese, and Najavits 2005; Dodes and Khantzian 2005; Schulz 2003).

Moreover, AAAP psychiatrists in this research "strongly encourage" all of their patients to join a Twelve Step program (AM/AP-17) and send "the bulk" of their patients to AA (AP-14). Other psychiatrists argued that AA teaches drinkers to "deal and cope with" alcoholism (AP-21) and one former president of AAAP said that if forced to choose only one treatment "it would be Twelve-Step" (AP-20). To repeat one nationally renowned addiction psychiatrist, "I think AA works because it's an extraordinarily sophisticated group psychological approach…. So I'm not in any great competition with that" (AP-12).

In 2006, the latest year for which data are available, four million addicts in the United States received some form of drug treatment, over half, 2.2 million, exclusively from Twelve Step programs like AA. Of the 2.5 million addicts who received "specialty" treatment in hospitals, rehabilitation facilities, or mental health centers, more than half, 1.5 million, also received self-help care (Substance Abuse and Mental Health Services Administration 2007). The Twelve Step program of recovery that Bill Wilson and Dr. Robert Holbrook Smith created is as fundamental to the medical treatment of addiction today as it was when ASAM originated 54 years

ago. Addiction psychiatry owns the medical treatment of addiction institutionally having won subspecialty recognition from the American Board of Psychiatry Neurology. Addiction medicine, despite its tradition of physicians in recovery or perhaps because of it, has won the day ideologically due to the ubiquity of Twelve-Step care and, specifically, the field's origins in Twelve-Step treatment that AA invented, ASAM has historically embraced, and that leading AAAP psychiatrists still begrudge addiction medicine yet recommend to their patients.

A final note on addiction as a medical problem. In 1784, Dr. Benjamin Rush, the father of modern psychiatry and a co-signer of the Declaration of Independence, declared that chronic drunkenness was a disease caused by distilled liquor and characterized by a loss of control over drinking that only permanent abstinence could cure (Levine 1978). "[P]ersons who have been addicted to [ardent spirits], should abstain from them *suddenly*, and *entirely*," Rush wrote in his widely circulated treatise entitled *An Inquiry into the Effects of Ardent Spirits on the Human Body and Mind*. "'Taste not, handle not, touch not,' should be inscribed upon every vessel that contains spirits in the house of a man, who wishes to be cured of habits of intemperance" (1811:32).[2]

Rush's model of habitual drunkenness was the starting place for medicine's responsibility for addiction. Rush discounted free will and attributed a power to beverage alcohol on the human body and mind which that substance did not previously possess. Medical professionals and recovering addicts, including addiction medicine physicians and addiction psychiatrists, have since modified and

even rejected the details of Rush's model. However, like Rush, currently they ascribe a mysterious power to drugs which drugs do not have despite scientific evidence to the contrary.

Social scientists have shown that opiate users experience addiction only if they recognize the physical symptoms of withdrawal, link those symptoms to their drug use, and use opiates again to alleviate those symptoms (Lindesmith [1947] 1968). Regular marijuana users learn to use the drug effectively and continue using *only* if it is pleasurable and harm-free (Becker [1953] 1963). Additionally, in some cultures drunken comportment is regulated by specific times, places, and occasions and not the pharmacological effects of alcohol (MacAndrew and Edgerton 1969). Related, addiction experts ignore self-control by "alcoholics" because, by definition, alcoholics have no control. If a drinker's self-control is acknowledged, one presumes the drinker is not a "real" alcoholic (Fingarette 1988). A "stake in conventional life"—a steady job, a family, and a safe home—keeps most cocaine users from using too much of the drug and helps heavy users quit (Waldorf, Reinarman, and Murphy 1991). Lastly, according to the late Norman E. Zinberg of Harvard Medical School, the "drug experience" is influenced not only by drugs themselves but by the mood or emotional state of the drug user and the environment in which drug use occurs (see Robins, Davis, and Goodwin 1974; Zinberg 1972; Zinberg 1984).[3]

Giddens argues that "an agent ceases to be such if he or she loses the capability to 'make a difference,' that is, to exercise some sort of power" (1984:14). A comprehensive discussion about the agency of "the great, unstudied 'silent

majority'" (Waldorf, Reinarman, and Murphy 1991:12) of drug users is not in the scope of this study. Suffice it to say that the concept of addiction as a medical problem and the competition this concept fueled between addiction medicine and addiction psychiatry fail to see that even heavy drug users "own" their drug use. This omission upholds the power of addiction medicine physicians and addiction psychiatrists over their clients, and the authority of the medical profession over addiction. Therefore, when Senator Biden proposed to change the names of America's research institutes on addiction to transform the way people talk about and think about drug abuse he was in fact suggesting no change at all. Genuine change will be realized only when addiction "specialists" and their political allies fully acknowledge the agency of the people they serve.

Notes

[1] Officials at AAAP estimate that approximately 10 percent of the organization's roughly 700 active members are recovering addicts.

[2] Although Benjamin Rush condemned distilled liquor, he also argued that the moderate use of cyder, malt liquor, wine, and coffee was nutritionally valuable and favorable for a healthy republic. For more information, see Rush, *An Inquiry into the Effects of Ardent Spirits on the Human Body and Mind, with an Account of the Means of Preventing, and of the Remedies for Curing Them* (1811).

[3] For a more thorough treatment of the sociology of drugs, see Reinarman and Levine, "Crack in Context: America's Latest Demon Drug" (1997a).

APPENDIXES

APPENDIX A

METHODS

To ask sociological questions … presupposes that one is interested in looking some distance beyond the commonly accepted or officially defined goals of human actions. It presupposes a certain awareness that human events have different levels of meaning…. It may even presuppose a measure of suspicion about the way in which human events are officially interpreted by the authorities.

—Berger (1963:29)

Historical research explains how institutional actors affect occupational dynamics (Halpern 1988). Historical sociology is thus central to the study of professions. "It is historical actors who create professional institutions. The practitioners who build them both respond to and are agents of social change. Their actions are understood best in light of the specific settings where they negotiate careers, the particular forces that impinge upon their labor, and contemporary perceptions of their interests and options" (Halpern 1988:160).

This dissertation on the competition between addiction medicine and addiction psychiatry to "own" the medical treatment of addiction began as a sociological and historical analysis of medical knowledge about alcoholism in the twentieth century. During the literature review for that project, I found a brief description of the addiction medicine "Unity Meetings" (see Chapter Three) that roused my "sociological imagination" (Mills [1959] 2000) and reshaped my research.

Was the field of addiction medicine created and professionalized after only a few days of negotiations in the early 1980s? Who participated in these talks and whose interests did they serve? To answer these and other questions about the Unity Meetings, I needed to interview the addiction medicine physicians and officials who attended them.

Data Collection

Deciding who to interview first is difficult. Ostrander (1993) suggests recruiting anyone powerful enough to contact other influential persons. However, "[g]aining access can be a tough proposition, even when the point of getting in is innocuous, well-intentioned, or attractive to key people" (Thomas 1993:81). Fortunately, a colleague introduced me to an addiction medicine physician who arranged for me to interview a former official from the field who helped organize the Unity Meetings. The interview lasted three hours and covered the Unity Meetings, the history of addiction medicine in New York and California, and the tradition of physicians in recovery in addiction medicine.

During the interview I also learned about the field of addiction psychiatry. "There is a whole river through this [history] that you're not aware of" (AMO-1), said my first interview respondent. Addiction psychiatry is recognized by the American Board of Medical Specialties, but addiction medicine is not. This medical and professional distinction is "fraught with tremendous political contention" (AMO-1). Abbott calls for "histories of [professional] jurisdictions—who served them, where

they came from, … how conflict shaped participants" (1988:325). The Unity Meetings were only a piece of the history of addiction medicine.

Interview Respondents and Interview Protocol

"Studying up" is critical to sociological inquiry (Ostrander 1993). Yet social scientists typically study people below their own professional standing (Hertz and Imber 1993; Ostrander 1993). "This imbalance in research focus is often benignly motivated and legitimated in terms of the need for knowledge … to solve … the prevailing social problems of the masses. Rarely is it acknowledged that the masses are more likely to be studied simply because they are powerless" (Hunter 1993:55). In contrast, elites such as congressmen, religious leaders, corporate officers, and community leaders are shielded from scientific inquiry because of their social power (Hunter 1993; Moyer and Wagstaffe 1987). Physicians should be added to this list. Like senators, priests, and chief executive officers, doctors employ a "high degree of learned competence" (Rueschemeyer 1972:5) which laymen do not possess. This was especially true of the physicians and psychiatrists I needed to interview. They created the fields of addiction medicine and addiction psychiatry, led the American Society of Addiction Medicine (ASAM) and the American Academy of Addiction Psychiatry (AAAP), and currently influence how the public and medical professionals nationwide conceptualize drug abuse.

With a list of individuals to contact from my first interview respondent, I began recruiting addiction medicine physicians, addiction psychiatrists, and officials from both fields. I identified prospective interview respondents with a variant of

purposive sampling called "expert sampling" (Trochim 2001). Expert sampling entails the recruitment of respondents who have specialized knowledge in a particular field or subject matter. "[I]t [expert sampling] is the best way to elicit the views of persons who have specific expertise" (Trochim 2001:57).

I recruited each respondent based on one or more of the following criteria: (1) their role in the development of addiction medicine or addiction psychiatry; (2) their clinical or scholarly contribution to addiction treatment; and (3) their current or former administrative position in ASAM or AAAP. These recruitment criteria emerged from a systematic review of the contemporary medical literature on addiction treatment, examinations of ASAM and AAAP's administrative structure, and respondent recommendations. "You get in and get useful data from [respondents] if you know others that they know and respect" (Ostrander 1993:12).[1]

Elite physicians are affiliated with hospitals, treatment facilities, academic medical centers, or professional societies (see Hunter 1993). As a result, their contact information is easy to locate. I contacted potential interview respondents by electronic mail, an efficient and reliable form of first communication. Nonetheless, "it is essential to have a problem or a question lead the way—something that suggests that the person with whom you want to speak is uniquely qualified in some way" (Thomas 1993:86). I tried to convey to every potential interview respondent that their medical knowledge and professional experience was unique and central to my research (see Lilleker 2003). I also left my recruitment message open-ended to justify covering a broad range of interrelated topics during the interview (see Table 4).

I recruited 24 interview respondents from a total of 32 persons I contacted: eight addiction medicine physicians, seven addiction psychiatrists, four doctors certified in addiction medicine and addiction psychiatry, one doctor certified in addiction medicine and general psychiatry, two former addiction medicine officials, one former addiction psychiatry official, and one official from the American Board of Psychiatry and Neurology (see Table 5 for more information).

I interviewed six former presidents of ASAM who served that organization between the early 1980s and the late 1990s and four current ASAM officers and board members. I recruited five former presidents of AAAP who helped create the field of addiction psychiatry and one former AAAP officer. Other interview respondents were active during the development of addiction medicine or addiction psychiatry and some remain active today. Three addiction medicine physicians and one addiction psychiatrist are retired from practicing medicine.

The addiction medicine physicians reported training backgrounds in general medicine, internal medicine, neurology, pharmacology, toxicology, and cardiology. They direct or serve as consultants to drug treatment centers, long-term care facilities, hospital-affiliated recovery programs, or have done so in the recent past. One addiction medicine physician has a full-time medical school faculty appointment while two others are part-time medical school instructors. The addiction psychiatrists are board certified general psychiatrists, most of whom have permanent academic or clinical appointments in medical schools or university-based medical centers, as do three out of four ASAM-certified addiction psychiatrists. Doctors from both

disciplines run private medical practices and come from New York, California, Georgia, Texas, Minnesota, Massachusetts, Connecticut, Nevada, Illinois, Virginia, Colorado, Rhode Island, Florida, Louisiana, or Mississippi. Most of the interview respondents were men.[2]

I conducted all but one interview between July 2005 and May 2006. Scheduling interviews requires flexibility. Twenty-one interviews were conducted by telephone to accommodate respondent work schedules and geographic distance. Face-to-face interviews are the "gold standard," but telephone interviews, which are more convenient and an effective, cost-efficient substitute, yield equally valid if not superior data (Aneshensel, Frerichs, Clark, and Yokopenic 1982; Rintala and Willems 1991; Smith 2005; Sneed, Edlund, and Kerr 1997; Sturges and Hanrahan 2004; Thomas 1993).[3] I scheduled most interviews during a respondent's office hours, but some interviews took place as respondents drove to and from work, walked their hospitals rounds, and vacationed.

Ostrander recommends "not approaching interviews with elites with an expectation of following … a logical progression of fixed questions" (1993:22). Physicians, like other elites, sometimes try to control the interview agenda (Ostrander 1993; Thomas 1993). I conducted semi-structured interviews to ensure that I could cover all appropriate topics and to stimulate a dialogue I could control (see Table 6 for the interview protocol). Most interviews lasted about 90 minutes and I tape-recorded each one. The Committee for the Protection of Human Subjects at The Graduate Center, The City University of New York approved the interview protocol.

It consisted of approximately 16 open-ended questions on the professional background of respondents, the concept of addiction and addiction treatment, comparisons between addiction medicine and addiction psychiatry, and medical specialty and subspecialty recognition.

I did not ask interview respondents about their personal history of substance abuse. However, four addiction medicine physicians, two ASAM-certified addiction psychiatrists, and one ASAM-certified general psychiatrist said that they are recovering from drug abuse. The few times I asked about the issue of physicians in recovery when a respondent did not raise the matter first, I did so, following Ostrander's advice, based on "particular situations and events known to me from independent sources that I could use to query … elites' knowledge or point of view" (1993:23). In other words, I referred to the "undercurrent of recovery" (AMO-1) among physicians who treat addiction, as this is how my first interview respondent described this subject to me. The informed consent form that interview respondents signed did not guarantee confidentiality. It stated that respondents "may request that certain data not be reported or, if reported, that measures be taken to ensure your confidentiality." No respondents made this request.

Historical Documents

I collected historical documents on addiction and drug treatment in the first half of the twentieth century from the New York Academy of Medicine, the Humanities and Social Sciences division of the New York Public Library, and the Rutgers Center of Alcohol Studies. I reviewed published minutes of ASAM board

meetings, ASAM newsletters, and primary and secondary source materials that covered the growth of addiction medicine. A bulletin on the origin of the California Society for the Treatment of Alcoholism and Other Drug Dependencies was particularly helpful (see Heilig 1993).

Historical data on addiction medicine and addiction psychiatry are also embedded in the scientific literature on substance abuse. In the 1980s and 1990s, journals such as *Alcoholism: Clinical and Experimental Research, Journal of Maintenance in the Addictions,* and *Journal of Addictive Diseases* (ASAM's former flagship publication which is now called *Journal of Addiction Medicine*) featured articles on the development of addiction medicine which included data on the medical background of ASAM physicians. The *American Journal of Drug and Alcohol Abuse*, the *American Journal of Psychiatry*, the *American Journal on Addictions* (the official publication of AAAP), and *Hospital and Community Psychiatry* published articles outlining how the field of addiction psychiatry organized, the origins of specialized training programs in the addictions for mental health professionals, and how addiction psychiatrists won subspecialty recognition from the American Board of Psychiatry and Neurology and the challenges board recognition posed for the field.

Staff members from ASAM, AAAP, and the American Board of Psychiatry and Neurology provided data on the membership and certification exams of addiction medicine and addiction psychiatry. Personnel from the American Board of Medical Specialties quickly responded to my request for the organization's bylaws regarding the formation of medical specialties and subspecialties.

Data Analysis

"[W]e [sociologists] have tended to view Theory as an end in itself," Gusfield writes, "as something that stands apart from its empirical base. In this, we are … pandering to our desire to be what the natural sciences have been; to our desire to state our laws of sociology as Newton did his laws of motion" (2003:134). I analyzed the interview and historical data inductively using the grounded theory method of Glaser and Strauss. Grounded theory originates from evolving ideas about the story data reveal. "Deriving a theory simply means identifying the interrelationship between concepts, and presenting a systematic view of the phenomena being examined, in order to explain 'what is going on'" (Wiener 1981:268).

Developing a theory rests on "coding" the data. Glaser and Strauss ([1967] 2006) recommend a "constant comparative" approach that is "concerned with generating and plausibly suggesting … many categories, properties, and hypotheses about general problems…. Some of these properties may be causes, … but … others are conditions, consequences, dimensions, types, processes, etc." ([1967] 2006:104). I began by importing the transcript of my first interview into ATLAS.ti, a computer assisted qualitative data analysis program used by social scientists and methodologists from across the academic disciplines (see Barry 1998; Gibbs 2007; Koenig 2004). I read the transcript repeatedly and created codes such as "unity," "addicted doctors," "specialty," "testing," and "psychiatry" to correspond to data on the unification of addiction medicine, the impaired physician movement, recognition for addiction

medicine from the American Board of Medical Specialties, the addiction medicine certification exam, and addiction psychiatry.

As I conducted and transcribed each subsequent interview, I repeated this procedure to identify phrases, sentences, and paragraphs that signified and modified the interview codes. Indeed, codes and categories should change as theories advance. "After coding for a category perhaps three or four times, the analyst will find conflicts in the emphases of his thinking. He will be musing over theoretical notions and, at the same time, trying to concentrate on his study of the next incident, to determine the alternate ways by which it should be coded and compared" (Glaser and Strauss [1967] 2006:107). As I reviewed original codes, new categories emerged such as "professional marginalization," "scholarship," "medical training," and "personal recovery." I asked interview questions that related to these themes and searched for historical data to corroborate my evolving ideas. "Joint collection, coding, and analysis of data is the underlying operation. The generation of theory, coupled with the notion of theory as process, requires that all three operations be done together as much as possible" (Glaser and Strauss [1967] 2006:43).

Some data corresponded to more than one analytic category. I cross-coded this information and decided where in the work these data should appear based on the inductive development of the analysis. For example, I coded the following interview text "recovery" and "treatment approach:" "I hold my status as a recovering individual as a very important part of my life…. I'm one of those people who will say it's a way of life…. [But] I'm not an ideologue about it. I don't insist that

everyone I see go to AA or do it the way I did it. But I am quick to share my own experience" (AM/AP-22). This text fit in Chapter Three on impaired physicians and Chapter Five on addiction psychiatry, but it was most applicable to Chapter Six on the "art" of addiction treatment. Alternatively, nearly every interview respondent raised the issue of personal recovery in addiction medicine before I could initiate the subject. First I categorized each of these remarks differently, but as the significance of physicians in addiction recovery became increasingly clear, I created the code "recovery" to consolidate and signify all of them.

As I continued to collect and analyze interview and historical data, I generated operational theories about "medical knowledge," "specialty status," "treatment responsibility," and "treatment ideology." I then developed—and in some cases retained—comprehensive codes that represented the work's central themes and chapters: "addiction," "certification," "medical specialization," "professional competition," "psychiatry," "recognition," "training," "treatment approach," and "recovery" (see Table 7 for more information).

Glaser and Strauss argue that sociologists need to do more than verify "great-man theories" ([1967] 2006:10). Although I am guilty of verification, "verifying as much as possible with as accurate evidence as possible is requisite while one discovers and generates his theory" (Glaser and Strauss [1967] 2006:28). My theory is that addiction psychiatry "owns" the medical treatment of addiction institutionally and addiction medicine "owns" addiction treatment ideologically due to the tradition of personal recovery in addiction medicine. "The form in which a theory is presented

does not make it a theory; it is a theory because it explains or predicts something" (Glaser and Strauss [1967] 2006:31).

Research Limitations

I interviewed several founders, presidents, high-ranking officers, distinguished physicians, and former officials from addiction medicine and addiction psychiatry. Accordingly, the interview data do not generalize to all addiction medicine physicians and addiction psychiatrists. I did not recruit every current and former officeholder in ASAM or AAAP, nor did I speak with every prominent member of either organization. Similarly, I did not interview rank-and-file addiction medicine physicians or addiction psychiatrists who are less politically active in their respective discipline and, as a result, perhaps less inclined to characterize personal recovery in addiction medicine as a central issue.

Related, representative samples of elites are difficult to obtain "because certain individuals or categories of individuals (possibly those with something to lose from being interviewed), refuse a request for an interview" (Richards 1996:200). I had trouble recruiting addiction psychiatrists. Five addiction psychiatrists did not respond to repeated interview requests, two of whom played important roles in the development of addiction psychiatry and are influential today. Perhaps scheduling was a problem, or maybe some psychiatrists worried that their participation in the study would tarnish their professional reputation. Other psychiatrists may not have been interested in the research. Some addiction experts who declined to be interviewed might be recovering from drug abuse and concerned that this

information, if revealed, could damage their medical career. Similar to other studies with elites, the interview sample in this study is small (see Richards 1996).

The physicians and officials I did interview offered their recollections and interpretations of significant events and people. This poses two potential weaknesses. First is the "halo effect," or losing objectivity due to the professional accomplishments of your respondents. "There are few formal devices I know of to counteract … halo effects," one researcher writes. "I can only offer my solution: to recall in my mind people whom I came to respect as a result of what I learned from them, not as a result of their press clippings, their formal titles, or their oratorical skills" (Thomas 1993:85). Telephone interviews eliminated the visual stimuli that produce the "halo effect," but I do recall one exchange in the large office of a well-dressed, nationally-renowned physician who lobbies Congress for medical training funds. Second, memory and reality can blur. "The nuances that can occur between hard fact and an individual's perception can create problems, particularly if the area under research has had little prior attention" (Lilleker 2003:211). Different interpretations of the same event are telling, but possibly subjective.

Telephone interviews have their own limitations. I could not follow tacit reactions and body language that might have led an interview—and the data—somewhere different. I relied on changes in voice tone and audible pauses. Poor telephone connections that interrupted discussions posed an added problem, especially when respondents used a cellular telephone. Telephone interviews also

limited the comparisons and conclusions I could draw about the professional setting and work environment of addiction medicine physicians and addiction psychiatrists.

The historical documents on addiction medicine and addiction psychiatry mitigated some of these weaknesses, but they too have limitations. Most notably, the historical data in the scientific literature at times reflected the professional and organizational opinions of its authors. As Freidson states, "to assume … that textbooks and other publications of academics and researchers reflect in consistent and predictable ways the knowledge that is actually exercised in concrete human settings is either wishful or naïve" (1986:229). The language of physicians is limited by their occupational affiliations (see Keller 1993).

Lastly, I translated medical terms, explained complex methods of drug treatment, and interpreted "evidence-based" research for readers who are not physicians or addiction experts. I suspect I have not flawlessly paraphrased or amply simplified medical terminology. I bear responsibility for my errors and how they have impacted the study.

These limitations notwithstanding, this dissertation offers a rich analysis of addiction medicine and addiction psychiatry from the principal agents of both medical disciplines. The interview and historical data depict a clear but complex story about scientific knowledge, professional competition, and the influence of the Alcoholics Anonymous Twelve Step program of recovery from two informative and equally valid perspectives (see Lilleker 2003; Richards 1996). I have tried to follow the data to a reasonable conclusion.

Table 4

Interview Respondent Recruitment Message*

Dear Dr./Mr./Ms._____:
My name is Christopher R. Freed…. Currently I am conducting dissertation research on the development of contemporary medical models of addiction treatment and, specifically, on the addiction medicine [and/or] addiction psychiatry approach. This includes consideration of medical specialty organizations like the American Society of Addiction Medicine [and/or] the American Academy of Addiction Psychiatry. Accordingly, given your addiction treatment expertise, not to mention your role in ASAM's [or] AAAP's history, Dr._____ suggested that I contact you to see if you would be willing to talk with me about my research and to perhaps be formally interviewed. At your request, I'm happy to provide you with more information about my dissertation work….
Sincerely,
Christopher R. Freed

*Edited to preserve respondent confidentiality and the researcher's private contact information.

Table 5

Interview Respondents

Respondent Code*	Sex	Date Interviewed	Mode of Interview
AMO-1	Female	November 8, 2004	In-person
AM-2	Male	July 27, 2005	Telephone
AMO-3	Male	August 2, 2005	Telephone
AM-4	Male	August 3, 2005	Telephone
AM-5	Female	August 23, 2005	In-person
AM-6	Female	August 29, 2005	Telephone
AP-7	Male	November 2, 2005	Telephone
AP-8	Male	November 11, 2005	Telephone
AP-9	Male	November 18, 2005 (continued November 21, 2005)	Telephone
AM-10	Male	December 2, 2005	Telephone
AM-11	Male	December 14, 2005	Telephone
AP-12	Male	December 16, 2005	Telephone
ABPNO-13	Male	December 28, 2005	Telephone
AP-14	Male	January 13, 2006	In-person
AM-15	Male	January 24, 2006	Telephone
AM/AP-16	Male	February 16, 2006	Telephone
AM/AP-17	Female	March 1, 2006	Telephone
AM/P-18	Male	March 4, 2006	Telephone
AM/AP-19	Male	March 7, 2006	Telephone
AP-20	Male	March 14, 2006	Telephone
AP-21	Male	March 22, 2006	Telephone
AM/AP-22	Male	April 11, 2006	Telephone
APO-23	Female	April 18, 2006	Telephone
AM-24	Male	May 31, 2006	Telephone

*__AMO__ = former addiction medicine official; __AM__ = addiction medicine physician; __AP__ = addiction psychiatrist; __ABPNO__ = American Board of Psychiatry and Neurology official; __AM/AP__ = physician certified in addiction medicine and addiction psychiatry; __AM/P__ = physician certified in addiction medicine and general psychiatry; __APO__ = former addiction psychiatry official. The number adjacent to each interview respondent indicates the order in which he or she was interviewed.

Table 6

Interview Protocol

Professional Background

What is your full name and professional title?
What medical certifications do you have related to addiction?
How long have you practiced addiction medicine and/or addiction psychiatry?
What is the extent of your past and/or present involvement in the American Society of Addiction Medicine and/or the American Academy of Addiction Psychiatry?

Addiction and Addiction Treatment

What is addiction?
What is the most effective treatment approach for addiction?
How do your medical colleagues define addiction and what do they consider effective treatment?
How important is fellowship training to addiction treatment?

Addiction Medicine and Addiction Psychiatry

What is an addiction medicine physician and/or an addiction psychiatrist?
If I am an addict, how would a certified addiction medicine physician treat me compared to an addiction psychiatrist?
Other respondents have talked about the "undercurrent of recovery" among physicians who treat addiction. Can you speak to this?
How does the field of addiction medicine view the field of addiction psychiatry?
How does the field of addiction psychiatry view the field of addiction medicine?

Medical Specialty and Subspecialty Recognition

Tell me about addiction medicine's efforts to acquire recognition from the American Board of Medical Specialties.
What promoted the development of addiction psychiatry and subspecialty recognition from the American Board of Psychiatry and Neurology?
Why is addiction medicine not recognized by the American Board of Medical Specialties? Why is addiction psychiatry recognized by the American Board of Medical Specialties?

Table 7

Data Analysis Codes

Code	Code Description	Coded Segments of Interview Text
Addiction	The definition or concept of addiction	51
Certification	Medical certification in addiction medicine and/or addiction psychiatry, including the clinical and professional similarities and differences between these certifications	66
Medical Specialization	Events related to the development of addiction medicine and addiction psychiatry, including each field's professional organization and desire for recognition from the American Board of Medical Specialties	69
Professional Competition	Ideological differences between addiction medicine physicians and addiction psychiatrists, and among addiction medicine physicians during that field's developmental years	135
Psychiatry	General psychiatry's interest in and contribution to the medical treatment of addiction during the twentieth century	53
Recognition	The medical-professional status of addiction medicine and addiction psychiatry and the significance of medical "recognition" for each discipline	164
Recovery	Physicians in recovery, including how these physicians affect addiction medicine and addiction psychiatry and attitudes toward physicians in recovery who treat addiction	117
Training	Medical training in the addictions for addiction medicine physicians and addiction psychiatrists	86
Treatment Approach	The methods addiction medicine physicians and addiction psychiatrists use to treat addiction	178

Notes

[1] After about 15 interviews, I repeatedly received recommendations to interview physicians and officials from addiction medicine and addiction psychiatry I had already spoken to or was scheduled to call. I concluded, therefore, that I had recruited interview respondents who were most relevant to my research. One time I agreed to interview a physician who contacted me after hearing about my study from a colleague. Other researchers have had similar experiences. See Ostrander, "'Surely You're Not in this Just to be Helpful': Access, Rapport, and Interviews in Three Studies with Elites" (1993).

[2] Men are overrepresented in the interview sample for at least two reasons. First, I recruited doctors with knowledge about addiction medicine and addiction psychiatry in the 1960s, 1970s, and 1980s when male physicians generally outnumbered females. See Nowlan, "Women Doctors, Their Ranks Growing, Transform Medicine" (2006). Second, the medical profession is still a male-dominated enterprise, particularly academic medicine which often generates the profession's leadership. See Ash, Carr, Goldstein, and Friedman, "Compensation and Advancement of Women in Academic Medicine: Is There Equity" (2004); Tesch, Wood, Helwig, and Nattinger, "Promotion of Women Physicians in Academic Medicine: Glass Ceiling or Sticky Floor" (1995); Wright, Schwindt, Bassford, Reyna, Shisslak, St. Germain, and Reed, "Gender Differences in Academic Advancement: Patterns, Causes, and Potential Solutions in One U.S. College of Medicine" (2003).

[3] Face-to-face interviews have limitations that telephone interviews moderate. For example, physicians are less forthright during face-to-face interviews that are conducted by social scientists compared to medical doctors. See Chew-Graham, May, and Perry, "Qualitative Research and the Problem of Judgement: Lessons from Interviewing Fellow Professionals" (2002). Status and age differences between respondents and researchers also limit data from face-to-face interviews. See Richards and Emslie, "The 'Doctor' or the 'Girl from the University'? Considering the Influence of Professional Roles on Qualitative Interviewing" (2000).

APPENDIX B

Key Events in the History of Addiction Medicine and Addiction Psychiatry

1934	Bill Wilson experiences a life-changing "hot flash" during his final stay at Charles B. Towns Hospital in New York City where he learns from Dr. William D. Silkworth that he suffers from an "allergy" to alcohol
1935	Alcoholics Anonymous is founded by Bill Wilson and Dr. Robert Holbrook Smith
1938	Marty Mann enters alcoholism treatment at Blythewood Sanitarium and sees a "white light" after reading a review copy of the Alcoholics Anonymous "Big Book"
1939	Alcoholics Anonymous publishes the Big Book that medical reviewers dismiss as unscientific; the Twelve Step program of recovery in the chapter "How It Works" is the Big Book's signature section
1941	Alcoholics Anonymous receives national exposure after Jack Alexander writes a glowing review of the fellowship in *The Saturday Evening Post*
1941	Dr. Ruth Fox, looking for help for her alcoholic husband, meets Marty Mann at an Alcoholics Anonymous meeting
1944	Dr. Ruth Fox contacts E. M. Jellinek at the Yale Section of Alcohol Studies regarding Marty Mann's plan for the National Council on Alcoholism
1944	Marty Mann forms the National Council Alcoholism, sponsored by the Yale Section of Alcohol Studies
1949	The Yale Section of Alcohol Studies and the National Council on Alcoholism separate
1951	Marty Mann creates a medical division of the National Council on Alcoholism called the New York City Medical Committee on Alcoholism, headed by Dr. Ruth Fox
1953	Dr. G. Douglas Talbott finishes his medical training and is then committed to a mental hospital for drug treatment during which time he dedicates his life to caring for addicted physicians

1954	Members of the New York City Medical Committee on Alcoholism establish an autonomous organization of physicians called the New York City Medical Society on Alcoholism; Dr. Ruth Fox becomes the New York Society's first president
1956	The American Medical Association calls alcoholism an "illness" for the first time
1958	Dr. Ruth Fox becomes the medical director of the National Council on Alcoholism
1958	Bill Wilson reminds physicians in the New York City Medical Society on Alcoholism that doctors and recovering alcoholics need to work together to treat alcoholism
1967	The American Medical Association calls alcoholism a disease that physicians are responsible for treating
1971	Dr. Jess W. Bromley and colleagues successfully lobby to change California state law so that physicians can treat addicts outside state-operated facilities
1971	Dr. G. Douglas Talbott establishes an impaired physician program in Maryland as the impaired physician movement takes shape in American medicine
1973	The American Medical Society on Alcoholism (formerly the New York City Medical Society on Alcoholism) becomes the medical division of the National Council on Alcoholism
1973	Dr. Jess W. Bromley and Gail B. Jara form the California Society for the Treatment of Alcoholism and Other Drug Dependencies
1973	The American Medical Association Council on Mental Health issues "The Sick Physician" report on substance abuse among medical professionals
1975	The first national conference of impaired physicians takes place at the St. Francis Drake Hotel in San Francisco, California
1975	Dr. G. Douglas Talbott forms the American Academy of Addictionology

1981	The California State Legislature passes the "Betty Ford Legislation" to establish special hospitals for addiction treatment
1983	The California Society for the Treatment of Alcoholism and Other Drug Dependencies administers the first certification exam in addiction medicine as a result of the "Betty Ford Legislation"
1983	Joan B. Kroc hosts the addiction medicine Unity Meetings at the J & R Kroc Ranch in Santa Barbara, California
1983	The American Medical Society on Alcoholism ends its tenure as the medical division of the National Council on Alcoholism
1985	The American Medical Society on Alcoholism, the California Society for the Treatment of Alcoholism and Other Drug Dependencies, and the American Academy of Addictionology unite and become the American Medical Society on Alcoholism and Other Drug Dependencies
1985	Drs. Richard Frances and Sheldon I. Miller form the American Academy of Psychiatrists in Alcoholism and Addictions
1986	The American Medical Society on Alcoholism and Other Drug Dependencies administers the certification exam in addiction medicine nationally for the first time
1987	The Center for Medical Fellowships in Alcoholism and Drug Abuse is co-founded by the American Academy of Psychiatrists in Alcoholism and Addictions to increase and improve medical training in the addictions for psychiatrists
1989	The American Medical Society on Alcoholism and Other Drug Dependencies becomes the American Society of Addiction Medicine
1990	The American Medical Association classifies addiction medicine as a "self-designated" medical specialty
1990	The American Society of Addiction Medicine orders that all applicants for the certification exam in addiction medicine must be residency trained
1990	The National Institute of Mental Health publishes the Epidemiologic Catchment Area study

1990	The American Academy of Psychiatrists in Alcoholism and Addictions proposes creating an addiction psychiatry subspecialty under the American Board of Psychiatry and Neurology
1991	The National Advisory Committee of the Center for Medical Fellowships in Alcoholism and Drug Abuse issues national consensus standards for fellowship training programs in the addictions that primarily serve psychiatrists
1991	The Group for the Advancement of Psychiatry Committee on Alcoholism and the Addictions argues that "addictionologists" have replaced psychiatrists on the "front lines" of drug treatment
1991	Addiction psychiatry wins board subspecialty recognition from the American Board of Psychiatry and Neurology
1993	The American Board of Psychiatry and Neurology offers the board subspecialty exam in addiction psychiatry for the first time
1996	The American Academy of Psychiatrists in Alcoholism and Addictions becomes the American Academy of Addiction Psychiatry
1998	The American Board of Psychiatry and Neurology requires that all applicants for the addiction psychiatry subspecialty exam complete a one year training fellowship that is approved by the Accreditation Council for Graduate Medical Education
2004 and 2006	The American Society of Addiction Medicine permits physicians to sit for the certification exam in addiction medicine under the "alternate pathway" designation

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