by William M. Loving, MD

Medical Director
Texas Star Recovery Program

512-462-6729
TEXASSTARRECOVERY.COM
1106 West Dittmar Road
Austin, Texas 78745

Articles by, William Loving, MD, ABAM

Medical Director, Texas Star Recovery Program
Board Certified Psychiatrist; Board Certified in Addiction Medicine by the American Society of Addiction Medicine Licensed Buprenorphine Provider by The National Alliance of Advocates for Buprenorphine Treatment
For over twenty five years Dr. Loving has treated psychiatric, chemically dependent, and dually diagnosed patients.

INTRODUCTION TO RECOVERY: FREQUENTLY ASKED QUESTIONS

1. Why are alcoholism and drug addiction called a disease?

By the time someone needs to ask for help for their alcoholism or drug problem, they have already made an effort and failed at trying to stop using the drugs and alcohol on their own. It is scientifically known that there are real, physical changes in the brain that affect this problem. So, once a person has to seek help, the problem has already become a biological or a physical one. At this point trying hard or using willpower just doesn't work. Real changes have occurred in the brain and in the rest of the body that render the person out of control.

Like other diseases, there are characteristic problems, predictable outcomes, and certain treatments that can help. Physical problems aren't controlled or overcome by willpower. The next time you have diarrhea try to "will" yourself not to have it. The disease of alcoholism and drug dependence is not a willpower problem, morality problem or intelligence problem. The disease badly affects these areas of your life, but perfectly good, smart and willful people get this disease, just like any other disease.

It's important to realize that this is a real physical problem or disease, but this doesn't mean you are not responsible for your behavior. You are the only one that can be responsible for your behavior. You are responsible for your recovery, especially now that you know you have a disease. (Chemical dependence=Alcoholism=Drug dependence=Addiction)

2. What kind of disease is this?

a. It's been called a <u>biopsychosocial disease</u> because it has effects on your biology, psychology and social functions.
b. It's a <u>self-induced central nervous system disorder</u>. The major component of the central nervous system is the brain and you have to ingest or give yourself a certain drug that has particular effects on the brain. When the problem becomes a disease the "self-induced" part is really out of your control.
c. It's a <u>chronic disease</u>. That means there's no cure, but there is a way to manage it very effectively so that it doesn't harm you. You can never safely use addictive drugs or alcohol again. Once you have this disease it never goes away. "Once a pickle never a cucumber."
d. It's a <u>serious and potentially fatal disease</u>. This disease is very serious and can kill you. It is also progressive and it is very important that you deal with it as soon as possible. Before it kills you dead, it kills you socially, kills off your relationships, kills your self-esteem, kills off

your potential and kills you in other cruel ways. It takes some work and inconvenience to manage this disease, but you will find it very satisfying and rewarding to do so. You have to expect to go through some trouble to manage this serious and potentially fatal illness. You will have to work at your treatment and make significant changes in your life, but it is worth it. As you recover, your self-esteem returns and your life becomes less chaotic and more manageable.

3. Why is the brain so important in this disease?

Drugs that stimulate a certain part of your brain get you high or change the way you feel. These drugs, including alcohol, have unwanted effects on other parts of your brain. These unwanted effects include impaired judgment, impaired social functioning, decreased balance, abnormal speech, low motivation, decrease in concentration, decrease in reaction time, mood swings, possible delusions and hallucinations, disinhibition (being unable to control/inhibit impulses such as anger), etc. The brain is where the action is. You have stimulated your brain with a certain type of chemical to get the wanted feeling or high but you can’t do this without affecting other important parts of you brain. This leads to out of control behavior. You can’t get the feeling you are hoping for without getting these unwanted side effects, too.

4. What is the difference between detoxification (detox) and recovery?

Detox, or withdrawal, is the medical management of the brain’s reactions to having an addictive or habit-forming substance taken away. The brain reacts with the opposite effect of the drug when you have abruptly stopped using that drug. For example, when cocaine is abruptly stopped, people feel tired, depressed, and hungry. Or, when people abruptly stop the tranquilizer Valium, they feel agitated, anxious, and the opposite of tranquil. When alcohol is stopped tremors, seizures, or D.T.’s can occur. Medications are temporarily used to take a person off alcohol safely and gradually. Withdrawal is like bringing an airplane in for a smooth landing.

The initial withdrawal phase or acute phase is over in about a week, give or take two days. There’s another phase, though, called post acute withdrawal, or protracted abstinence syndrome that refers to the next few weeks or months that it takes the brain to get all its systems working again and its chemistry all back into balance. In this phase your emotions may be up and down and your ability to concentrate and remember things may be impaired. Most people get through this phase in three months but for some people it may take up to a year until they feel like they are “firing on all cylinders.”

Recovery refers to learning to manage this serious and chronic disease. It’s what you do to change your life so you can live in a satisfying way without drugs or alcohol. Everyone needs a plan of recovery and needs to follow their plan. If you follow a well worked out plan of recovery you will never have to go through detox again and you will keep the illness from harming you anymore.

5. What's the difference between sobriety and abstinence?
Abstinence means giving up the drugs and alcohol. Yes, you need to do this to manage this disease, but if this is all you do you will just feel depressed and irritable. You will feel deprived and be miserable. Some people call this a "dry drunk" or 'white knuckling." Sobriety is a positive thing and not deprivation. Sobriety is giving up the drugs and alcohol, but putting some positive and healthy things in the place of drugs and alcohol. It is replacing what drugs and alcohol did for you with healthy and functional activities and attitudes. Sobriety includes forming a healthy support group, using natural highs to give yourself pleasure, and finding healthy ways to manage stress and cope with uncomfortable feelings. Managing this disease is best done by seeking sobriety.

6. What is the difference between a willing attitude and a willful attitude?
A willful person is someone who must do things their way. They tend to be stubborn and feel like they "know it all." They have a closed mind. They are going to use their own "self will" and they are not open to any suggestions. Remember, by the time you reach the need for treatment you've already tried your way and it has not worked.

In recovery it is important to have a "willing" attitude and accept suggestions, try new approaches, or have a new attitude. Being open minded is the key. You really can't get sober on your old information, so it is important for you to be willing to listen to the new information given to you about the disease of chemical dependency and alcoholism. It is also important for you to be willing to try some new approaches and steps to reach sobriety. These suggestions and tips given to you by your nurses, sponsors, counselors and doctors are ones that have proved to be effective over the years, and if you follow these approaches with a willing attitude you are bound to be successful.

7. Why do all the good programs emphasize using AA or NA?
The twelve-step approach of AA or NA began a little over 60 years ago. These groups and this approach have helped millions of people since they were started. The approach started with Alcoholics Anonymous which never had a CEO, a president, a marketing director or a director of missionary services. No one has ever made money from the AA or twelve-step approach and yet, meetings have spread over the whole country and over the whole world. In Austin alone there are more than 50 meeting sites, not to mention meeting times. This approach to recovery has flourished and spread only because it's effective. You don't have to like everything about this approach, but it's important for you to tap into it, as it has proven the most effective approach to managing this disease and achieving sobriety. It helps to look at the twelve-step program as being a valuable tool for you to use to become sober. Remember, you are not the tool of AA or NA; they are tools for you to use to reach your goal.

8. Why do I need a sponsor?

It's difficult to make changes to become straight and sober and it really helps to have a support group that can understand you. AA and NA provide this support. This is an important function of AA and NA, but there is more to it than that. It is important to get a sponsor. A sponsor is basically a guide to help you through the stages of sobriety. A sponsor is a person who has more experience than you and knows how to work the twelve steps. You are not just sponging off the sponsor; in fact, you are really helping the sponsor to progress in their later stages of sobriety by allowing them to sponsor you. They say, "You have to give it away to keep it." It is very important to work through the twelve steps of recovery and the sponsor can help you to do this. The twelve steps help you through the various stages of recovery. It helps you reach gratifying sobriety and helps you with new methods of coping with stressors in your life.

You can look at AA or NA as having two basic parts. The first part is the support group; the second part is the sponsor plus the step work. You need both parts of the program.

9. Does recovery or treatment work?

Yes, it really does work and it is guaranteed to work or "your misery will be refunded." There are many people who have reached their goal of sobriety and managed the disease of chemical dependency effectively and happily. You can do this, too. The disease of alcoholism or chemical dependency does not do a halfway job on you; it does a "hundred percent' job on you. If you put in a half-hearted effort for treatment, you can expect to lose and fail at recovery. It is important to include AA/NA and the twelve steps in your plan. Treatment staff can help you come up with your own recovery plan. The next step is for you to follow your plan. You have to be willing to try some new approaches and new things, but they will pay off.

Imagine you did not know how to bake, but wanted to make, a good cake to eat. First, you would have to find out what ingredients are needed and get a recipe from someone that had experience baking cakes. In baking, all the ingredients are important it wouldn't taste very good if you left out the sugar, eggs or the flour. After gathering the ingredients you would need to follow the recipe in detail to produce a cake that is tasty. A recovery plan is very much like this. You need certain fundamental ingredients and you need to follow instructions. If you do this you will reach your goal and be successful in reaching sobriety. It is very common for people to foul up their recovery by leaving out important ingredients such as a sponsor or step work or meetings.

If you have a psychiatric illness such as anxiety disorder, depression, bipolar illness or other psychiatric problem, it is important to have this illness treated and stabilized or it will be very difficult for you to recover from your drug and alcohol problem. This is also very possible, and you just have to work with your psychiatrist to have your psychiatric problem stabilized so you can reach sobriety and work your plan of recovery.

10. How does the family figure into this disease and recovery?

In your recovery you will make some significant changes in your life that go way beyond just giving up drugs and alcohol. You will also learn some new information about the disease. It is important that your family understands some of this new information and also understands why you are making some of the changes you are making. It's not enough just to give up drugs and alcohol. As we discussed earlier, abstinence, or giving up things, is not enough; the goal is sobriety, living a full and enjoyable life without substances.

Al-Anon is a part of the twelve step program designed to help families with the adjustments needed for sobriety. Sobriety is a family matter. Families suffer from the disease of chemical dependency and, in some respects, they become sick as well. This is referred to as co-dependency and it is important for the family to get help for their own sakes; help for the damage that was done to them. Being involved in family recovery will also help your family be supportive of you as you go through your recovery. Sometimes it's important for the family to receive some counseling and therapy. It is very possible for the family to heal and recover along with you.

IS IT A DRUG OR ALCOHOL PROBLEM?

People with drug and alcohol problems often are the last to recognize and accept their chemical dependency problems. In their own mind, they deny the problem, and they rationalize their difficulties and lack of control. Often, family members unconsciously collaborate in this denial and rationalization. The spouse, family member or friend may make excuses for the chemically dependent person, call in sick for the person, pay off hot checks and take care of other responsibilities for them. This "codependent behavior" or "enabling" just cushions the fall of the out of control persona and "enables" the disease of the chemical dependency to continue and flourish.

People in the throes of addiction tend to act in irresponsible, unethical, amoral and erratic ways. These people are generally decent, intelligent and very sane people when not affected by drugs and alcohol. When the brain is bathed by addictive substances, behavior becomes very erratic and out of control. Most of these substances "disinhibit" the brain. This means that the usual inhibitions and social constraints are not in place, so that the person "shoots off their mouth," acts out their anger and is socially inappropriate. It is interesting that if we visit a recovery room where people recover from anesthesia after surgery, you will see people that are groggy and out of control. In the recovery room, the nurses expect the person to "not be themselves," however we readily understand that it is due to the brain being disinhibited and affected by the anesthesia. We don't blame the behavior on the person's basic personality, but rather on the chemicals. When people take addictive substances, their brain is affected in

much the same way and, of course, they are “not themselves” and therefore act in inappropriate ways.

So, if a person around you acts in an erratic way and has 101 excuses for his or her behavior, you might suspect an alcohol or drug problem. People with drug and alcohol problems generally don’t look very healthy. This is because they are generally not sleeping or eating well. They are not taking care of themselves and the drugs and alcohol cause stress on the body. Many people with chemical dependency problems are extremely capable and likable people when not intoxicated or affected by drugs and alcohol. The person may function quite well for several days but then suddenly be overly agitated, angry, depressed or will act inappropriately. We usually don’t actually see the person ingesting the drug, but we do see the effects on his or her behavior.

If you suspect someone you know has a drug or alcohol problem, what do you do? If you confront the person in the wrong way, you will get a very defensive and angry response. Remember, the chemically dependent person even denies to themselves they have a problem and certainly they will deny it to someone confronting them in a critical way. You should look for a pattern of behavior and give the person the benefit of the doubt, but only to a point. It is a good idea to be open, direct and honest about your concerns. It is not helpful to be judgmental, critical and angry when confronting the person. Concern for the person’s well-being should be communicated. Sometimes it becomes necessary for a group of concerned persons to confront the person in a very loving, yet firm way. This is called an intervention, and there are trained counselors who know how to organize this type of confrontation. There is not one perfect formula for dealing with people who have chemical dependency problems, but is important to be direct and honest when dealing with them. The good news is that people with chemical dependency problems can recover and can change their behavior through treatment and involvement with 12-step programs such as Alcoholics Anonymous or Narcotics Anonymous.

THE SELF-INDUCED CNS DISORDER

The major part of the CNS (central nervous system) is the brain. Drugs of abuse and alcohol do what they do by stimulating parts of the brain. The “good” effects, or those wanted by the user, include the “high” and the ability to change unwanted emotions to cope with stress. The “bad” effects include such things as slurred speech, poor balance, poor judgment, disinhibition, blackouts, and others. When alcohol and drugs are ingested they affect the whole brain so you cannot have the “good” effects without experiencing some of the “bad” effects.

The “bad” effects are really side effects because, for example, no one takes drugs or drinks to stagger, embarrass themselves, have blackouts, or get DWIs. These are “bad” effects that

come along with the desired effects, and are disordered or pathological effects of the brain. The side effects happen while the drug is in the system, but also linger after use is stopped.

Encephalopathy is a term used by neurologists to refer to a brain sickness (encephalo = brain and pathy = sickness). A person is said to be encephalopathic when their behavior or function is disrupted by a sick brain. Encephalitis is a brain disorder caused by an infection or inflammation (such as seen in the brain's involvement in meningitis which is caused by a bacteria or virus.) Alcoholism and chemical dependence are not infections, yet they cause a person to be encephalopathic due to immediate or ongoing drug use. The encephalopathy is easily seen in the acute phase of detoxification. For instance, the first week off of alcohol a heavy drinker's brain is so sick it may be at risk for seizures, tremors, hallucinations, confusion, anxiety, depression, and other serious central nervous system problems. After this acute phase with the drug or alcohol still stopped, the post acute phase or protracted abstinence phase begins, sometimes lasting weeks or months. The encephalopathy then is seen as poor concentration, mood swings, poor memory, and levels of confusion.

People are also encephalopathic when waking up from anesthesia after surgery. Anesthesia has a lot of the same side effects as alcohol and drugs. Patients can be out of control in behavior (just like a chemically dependent person), while coming out of the effects of anesthesia, so they are closely monitored and supervised in a special room called the recovery room. Doctors and nurses all have amusing recovery room stories like the story of the church lady who curses like a sailor when coming to, or the prim and proper judge removing his clothes and pinching the nurses. These stories are amusing and the people are easily forgiven for their antics because the drugs were given by a doctor in a socially acceptable way.

In anesthesia the drugs that affect the brain are given by professionals for the purpose of getting through surgery. In chemical dependency and alcoholism, the substances are self-administered for a very self-centered purpose and not so easily excused. The changes in behavior in both cases are very much the same because the substances cause an encephalopathy. The brain doesn't go back to normal functioning immediately after the drug is stopped. If the alcohol and/or drugs are used for a prolonged time, the encephalopathy will linger long after they are stopped. Alcoholism and chemical dependency cause encephalopathy and the problem is a self-induced CNS disorder.

THE UNIVERSAL TOOL FOR SOBRIETY

Doctors should never be reluctant to recommend AA or NA (similar to AA but more emphasis on drug dependence) to their patients with chemical dependency problems. AA and NA only exist because they are effective. No one has ever profited financially from AA/NA, and in fact there has never been a CEO, president, marketing director, or director of missionary services. AA and NA have become the universal tool to become straight and sober; just like the jack is the universal tool to change a flat tire.

Some patients ask me "Isn't there another way to get sober than AA?" Well, sure there are other ways to reach a goal; it's just that using AA/NA is probably the best and most effective way. It's a very useful tool to help get off and stay off drugs and alcohol. It is the patient's tool; the patient is not the tool of AA/NA. Some newcomers to meetings feel like they will be swallowed up by the program and lose their identity or become a tool of the program. This doesn't happen. If anything, the person becomes more who they really are.

The program is a method or tool to reach the goal of sobriety. It is tested over time and really works if it is used fully and in the right way. The right way means not just going to meetings, but also getting involved with a sponsor and working the 12 Steps. The program has helped millions of people across this country and the rest of the world.

It's easier and quicker to dig a hole with a shovel than to try to do without this useful tool. One person may push the shovel into the ground by using his feet, another might swing it up and down hitting the ground, while someone else might scrape the ground with it. People might use the shovel in slightly different ways, but still find that it can't be beat to get the job done. AA/NA can be used in somewhat different ways by different individuals, but if it is used without ignoring the fundamentals, it is a very effective way to get the job done.

There are a couple of books on getting sober without AA. These books are always good sellers because initially no one wants to admit they are an alcoholic or an addict, and so many people resist the idea that they need AA or NA. The methods suggested by these books tend to be complicated and involve several approaches such as meditation, massage, therapy, exercise, diet, acupuncture, and other ways of getting help. This method tends to be very time consuming and expensive. Each of the individual disciplines recommended has something to offer, but even if a person goes to each type of therapy, this method still doesn't quite offer what AA/NA alone can give. AA/NA are one-stop shops that are effective and free. It is easier to use this 12 Step approach and deal with whatever complaints the newcomer has than to reinvent the wheel, or the shovel, or the jack.

AA/NA is the universal tool to use to get sober, and doctors should not hesitate to refer patients to meetings. Meetings can be found by searching the internet or by dialing information and asking for AA.

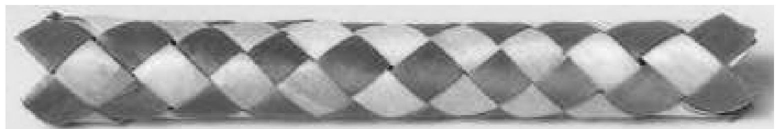
THE TAIL WAGGING THE DOG

Imagine separating the brain into the areas of higher functions (above the ears) and lower primitive functions (below the ears). The higher functions such as speech, voluntary movement, will power, logic, judgment and ethics are located in the big wrinkled part of the brain above the ears. This area is called the cerebrum or neocortex. The primitive functions which are involuntary and instinctual in nature are located lower in the underbelly of the brain. This area is called the mid-brain and brain stem.

You might think that the pleasure or reward center is located in the area of higher function - but it is not. It is located in the primitive mid-brain. Stimulate this discrete area of the brain known as the reward center and the person feels pleasure, euphoria, or "high". This is "where the action is" in the alcoholic or chemically dependent person's brain. Because of their chemical structure, certain substances like alcohol, marijuana, cocaine, opiates and other drugs of abuse have their primary action at the reward center. When stimulated the reward center does two things - it makes chemically dependent or alcoholic people feel "high" and then it sends a message to the rest of the brain saying "do that again".
It has been discovered, through animal studies and sophisticated brain scans, that the alcoholic and chemically dependent person has an ultra-sensitive reward center, and this type of stimulation causes it to overreact. That means the chemically dependent person not only gets a higher "high" than the average person, but, even more significantly, gets super strong messages saying "DO IT AGAIN!" Not only are these messages to repeat the behavior very strong, but they come from the primitive area of the brain. This means they trump control by the higher function area of the brain. Chemically dependent people find themselves obeying the primitive brain's message even though it goes against their own logic, judgment, and ethics. The primitive brain then starts to run the show or control behavior, and the higher brain is just along for the ride.

When alcohol and/or drugs are actively used, the primary motivation and control of behavior is coming from the part of the brain below the ears. Above the ears the cerebrum just spends its time rationalizing, explaining away behavior, and lying, if necessary, to cover its tracks. One author said the brain gets "hijacked" by drugs and alcohol. When it comes to behavior, it is like the tail wagging the dog.

CONTEMPLATING THE CHINESE FINGER TRAP



The first impulse to free yourself from a Chinese finger trap is to pull hard, but this only entraps you more. The way to get free is the opposite—give up the struggle. Likewise, brute

force, strong determination, or sheer willpower do not work to free a person in the throes of chemical dependency. Nearly 20% of our population struggles with the dangerous and destructive central nervous system disorder of drug addiction and alcoholism. This disorder is often inherited but can be acquired, and is due to a particular primitive part of the brain that grossly overreacts to drugs that induce euphoria.

Divide the brain horizontally in half at the ears, and you have the neocortex above the ears which contains the higher functions such as logic, speech, thought, and willpower, while below the ears you have the primitive or instinctual brain. The key part of the brain involved in chemical dependency is just below the ears at the reward center (mesocorticolimbic system.) This reward or pleasure center registers the feeling of euphoria or "high", and then reflexively urges you to repeat the experience that induced the pleasure. If the reward center overreacts, not only is the euphoria extremely intense, but the reflex urges are very powerful saying "DO IT AGAIN!"

Strong messages like this from the instinctual part of the brain overpower willpower, which is a function located above the ears in the neocortex. When a child says, "If you don't let me have what I want I'll hold my breath till I turn blue and die," we are amused. We know the child will breathe in due time—the breathing center in the instinct actual brain stem will overcome the child's willpower.

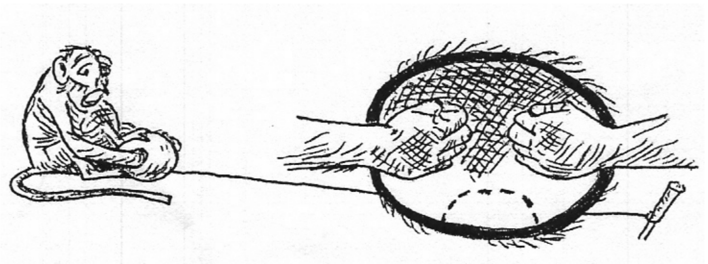
Drug addicts and alcoholics truly experience a more intense "high" because their reward center is overly sensitive or reactive to certain chemicals. Ask a non-alcoholic how alcohol makes them feel, and they will give an answer such as, "Oh, it makes me feel kind of loose and giddy—calmer and uninhibited maybe, but at three or four drinks I start to feel dizzy and out of control so I quit." An alcoholic will answer, "It makes me feel GOOD and four drinks is great—five drinks is better—and six is better still so I keep drinking and lose count." The alcoholic's reward center is very stimulated; it says "DO IT AGAIN" repeatedly; they feel great; this primitive part of the brain is running the show and they become out of control. The neocortical functions such as logic, willpower, morals, and ethics are superseded by the strong reward center impulses. And what is more dangerous, the brain is disinhibited and the vital neocortical functions including insight and judgment are impaired by these same chemicals. The chemically dependent person feels the "high" while those around him or her only experience that person's misbehavior due to the short-circuited neocortical functions.

So, do we have a reward center so cocaine, pot, alcohol, and opiates have a place to work? Of course not. The reward center is naturally stimulated by sex/intimacy, exercise, food, collecting/shopping, a job well done, and artistic/spiritual experiences. All of these categories of natural "highs" give us survival benefits, and yet isn't it interesting that any one of these natural "highs" can create problems as well if compulsively overdone. Remember, there is Sex and Love Addicts Anonymous, Over Eaters Anonymous, Debtors Anonymous, Workaholics, Compulsive Exercisers, and even a Fundamentalist Anonymous group. The natural "highs"

when done in moderation, though, do not disinhibit the brain and impair the other neocortical functions, and so are less likely to become problems.

When chemically dependent people become out of control they are functioning very much like the primate in this monkey trap picture:

"…a coconut with a small hole in each end and fastened to the ground by wire or cord. Bait is placed inside. Monkey reached in, closes fist, and won't let go even though he can't pull fist through hole."



This is an illustration from a World War II survival manual for downed pilots which instructs a hungry pilot how to catch a monkey for food. The trap uses the strength of the monkey's instincts against him. The monkey will hold onto the food to the point of being captured rather than do the smart thing and let go. Chemically dependent people will hold on to their drugs and alcohol in the same manner to the point of great loss and even death. In this way, the supersensitive reward center, in the instinctual brain, takes over and controls the human's life.

So what does all this have to do with the Chinese finger trap? Struggling and willpower won't free a chemically dependent person any more than pulling can free a person from a finger trap. After willpower fails, and it always does in a true addict or alcoholic, the chemically dependent person has to use a different approach than their first impulse. They must stop fighting and accept their powerlessness. This is the first step of Alcoholics Anonymous Twelve Steps to recovery.

This surrender frees up a great deal of energy so that the person can accept help and make the profound changes necessary to recover. After this stage the power can shift to the functions of the neocortex to establish an ongoing, proactive, sobriety plan based on new information about the disorder. Now, effective skills and tips can be learned in treatment to manage the disorder. The person can find real power and freedom in the treatment axiom of "surrender to win," just like freedom from the Chinese Finger Trap comes by doing the opposite of what you might think.

THE SUBCULTURE OF RECOVERY

If you are in recovery or work in the field, you are very aware of a strong subculture of recovery. People across all economic, educational, ethnic, and social spheres are actively engaged in the same goal of staying sober. Sobriety is not passive, but is an active, proactive, ongoing endeavor. People become engaged in it as an important part of their life.

This subculture usually includes 12 step meetings. The subculture has places to meet; meetings have special rules; and members speak a special language. Members have a hierarchy such as sponsor – sponsoree and of newcomer – old-timer, but mostly it is a very egalitarian group. To join you must have the problem and a desire to work on sobriety.

The language of recovery is not truly a foreign one, but certain words or phrases are used in particular ways that not everyone outside will understand. Group members talk about a Higher Power, the Big Book, letting go, and sober birthdays. The array of phrases, platitudes, and sayings are well-worn and many. They are all tried and true, reinforcing "horse sense" about living a balanced sober life.

Newcomers can be confused by the language used in the group and may see the "clichés" and language as a barrier to joining. Some patients have told me they are fearful of becoming a robot-like character who just spouts clichés. These clichés are reminders of common sense ways to live life gracefully and many are actually "secrets of life", like the Serenity Prayer and "One Day at a Time." If a person examines each of the common phrases used in the group it is doubtful he or she will disagree with any of them.

The subculture of recovery is very important for the recovering alcoholic and addict because either they were deeply involved in a using subculture or were very isolated. The support and the power of the group are vital to the newly recovering person. Changing to a sober lifestyle is possible when a sober support system is in place. It would be very difficult to build such a support group from scratch, and the subculture that exists already has a lot of depth and valuable elements that would be impossible to duplicate.

This subculture is rather silent and somewhat invisible to the outer culture as it protects the anonymity of its members. No one brags about being a member, and there is a tradition that urges members not to proselytize or speak for the group. Even though it is silent and virtually invisible within the culture, it is vibrant, dynamic, and very active.

Every reputable and effective recovery program allies itself with this subculture of recovery. Twelve step orientation and facilitation groups are a part of the curriculum. In-house meetings and visits to meetings in town are also important activities in these programs. One of the main goals of a treatment program is to launch patients or graduates into the subculture of recovery in their local area. The successful people enter this dynamic subculture, and become a part of the flow and current of this strong moving, benign river of change.

GIVE TO KEEP

Sobriety lives at Steps 10, 11, and 12, and Step 12 is really the "crowning glory." The "old timer" helping the "newcomer" makes for growth of the program, continuation of the traditions, and sobriety to really set in for the "old timer." Who gets the crowning glory is debatable in this process—the sponsor or the sponsoree? Well, really no one gets glory or a crown, but both parties benefit tremendously.

The sponsoree has a chance to be mentored, and this may be the first time he/she has received such benign teaching or help from a more experienced adult. He can learn to trust, to be somewhat dependent in a healthy way, and be guided by tried and true principles of living through the Steps. He can benefit from the traditions and ways of sobriety handed down through the history of AA and NA. It would be interesting to see a family tree of sponsors and sponsorees through the history of the program.

The sponsor, I believe, probably receives the most benefit. The sponsoree will have a chance for this crowning glory, too, by finally getting to Step 12. Imparting the principles and fundamentals of living a sober life truly helps the sponsor learn what sobriety is all about. In medical school it was said to learn how to do an operation you have to "see one, do one, teach one." Then you really have it. The sponsor gets to teach about sobriety, and this is when he/she can really have it.

The founder of the volunteer program where I work, Scott, has often told me that the sponsors and temporary sponsors are really the ones that profit the most from the volunteer program. As I am just discharging newcomers from the treatment program, I have been more concerned about the newcomer getting all they need to enter recovery. I know these newly discharged patients profit if they can accept help from the old timers, AA/NA volunteers, or sponsors. It is gratifying to see this happen, but Scott has finally helped me understand how valuable this experience is for the sponsor or temporary sponsor. It really helps the sobriety set in and bring these old timers to a new level of sobriety—an even more profound, gratifying, and likely, lasting level of sobriety.

If you look at the eyes of the newcomers, sometimes they are dull, confused, and lack a spark unless the spark is out of fear. Look at the eyes of someone later in sobriety, especially those that are sponsoring others, and you see a different kind of spark. It is a gleam—a spark that is like a luster, and reveals a state of life that anyone would want to have for themselves. The fearful spark eventually turns into that lustrous spark as the person moves through the 12th Step.

Every year Scott and I have a celebration of sobriety with the other volunteers. I initiated this little breakfast where we recognize the valuable service of the volunteers-- almost like an awards banquet. Scott said, "Oh no, our reward comes in the service, so let's just call it a

celebration of sobriety." Of course, he was right. We came up with a little button we hand out to everyone involved that says simply, "Give to Keep." I believe this is the shortest way to express the 12th Step because you have to give it away to keep it. I encourage everyone in recovery to work your way to the 12th Step and then actively do it.

BETTER THAN NORMAL

Alcoholics and chemically dependent people certainly don't act normal when the disease starts to flourish. They are out of control eventually in every area of their lives and have multiple self-imposed losses. In fact the only guaranteed way to have a dysfunctional life (not to mention dysfunctional family and relationships) is to be alcoholic or chemically dependent. This disease produces the height of dis-order, dis-control, and dis-function—anything but normality.

The transition from the out-of-control life of the alcoholic/addict to that of a person in recovery is a rocky one. After detox, post acute withdrawal, and the early phases of recovery comes a gradual return of appropriate function. With AA/NA involvement this function becomes shaped by the step work, feedback from sponsors, feedback from other AA members, and by the many aphorisms and sayings in AA.

Honesty and accountability are two vital traits of sobriety. Isolation is replaced by a new sober support system consisting of other recovering people and meetings. The language used in meetings and among other sober people really supports a return to more normal function.

Sayings like "one day at a time", "let go and let God", "surrender to win", and "keep it simple" are tried and true aphorisms that a wise old grandparent would say to advise their younger loved one. The Serenity Prayer is often repeated and it contains a philosophy of life that must be one of the secrets of living a balanced life. These oft repeated words of wisdom are good reminders for recovering people of how to live gracefully, humanely, and effectively in this world. The group support helps these ideas sink in.

A psychoanalyst who knew about recovery once said to me, "The only good thing about being alcoholic is you get to go to those meetings." Newcomers do not always feel that way, but as one grows in recovery they become grateful for the 12 step program.

People who do not have the disease (80-85% of the population) do not have such supportive groups to go to, and don't have frequent reminders or tips given to them on how to live sober and balanced lives. "Normal" people don't usually do an inventory of their lives, look at their contribution to problems, or examine their own character defects. Oh, some do that in analysis or therapy or counseling, but not as a part of a supportive community of people all striving for the same goal, i.e. a sober lifestyle.

You could say chemically dependent people/alcoholics "get to" do a 4th and 5th step, go to those meetings, and be involved in sponsorship.

All of this work in 12 step meetings and the program helps a human being live a high functioning life (pun not intended) – one that is not controlled by impulses. Becoming wise, self-examining, accountable, honest, open, and non-judgmental is part of the program of recovery. Then, to top this off, giving back to others is the 12th step, and promotes caring for others and spreading this whole philosophy. That is why it can be said truthfully that a person in recovery becomes "better than normal."

DENIAL: PSYCHOLOGICAL OR ORGANIC?

A severe alcoholic was on the detox unit and was receiving high doses of Librium to prevent seizures, DTs, and other severe withdrawal problems. The man did not appear drugged, he was alert and well-oriented. The second day in the hospital, when the lab results were on the chart, I went over the results with the patient to discuss mainly the liver damage that was discovered in the lab tests. The numbers (elevated GGT, AST, and ALT) indicated liver damage that could objectively make the point, again, that it was unsafe for this man to drink. After showing the attentive man the abnormal numbers and explaining their meaning, the man politely and blandly said, "Now, can I go home today?" His detox symptoms were attenuated by Librium, but he was no where ready for discharge from the hospital. He was grossly unaware of his severe disease even when given concrete and graphic evidence. His unawareness or denial was so profound, that he seemed totally unable to compute the information given to him about the problem.

This man reminded me very much of another patient I had seen who was paralyzed on the left side due to a right-sided traumatic brain injury. She was unable to care for herself due to severe problems related to the paralysis but also due to cognitive problems caused by the brain injury. She was unable to recognize the fact that she was severely impaired and was even unaware of her paralysis. When her paralyzed arm was held up in front of her face, she was still unable to admit to her paralysis. In fact, she had a neurological condition seen in right hemisphere brain damage known as *anosognosia.* She was totally unable to realize her problem.

Anosognosia is literally "without disease knowledge." The term was coined in 1914 by Babinski to describe the neurological unawareness of the deficit of hemiplegia or paralysis of one half of the body. Curiously, this syndrome happens when the right side of the brain is damaged by a stroke or injury, but not if the left side is damaged instead. This is a biologically or organically based unawareness of a severe deficit. A great discrepancy exists between the patient's knowledge of a disability and the objective evidence of the disability.

Psychological denial is a prominent part of alcoholism and drug dependence. Denial is psychologically motivated to protect the ego from the distress of catastrophic events. It serves to help the person cope with painful emotions that go with the disease of chemical dependency. All chronic diseases come with some degree of denial as no one wants to believe they have a severe or chronic illness. For example, juvenile diabetics often stop taking their insulin and may eat several candy bars early in the course of their diabetes while they are still struggling with denial. Denial interferes with awareness of the problem and, when strong, interferes with and delays recovery.

Besides stroke and traumatic brain injury, *anosognosia* is seen in other organic brain disorders such as Alzheimer's disease and Korsakoff's psychosis. The severe memory deficits of Alzheimer's disease account for much of the unawareness of the disease that accompany this disorder. Korsakoff's psychosis is a disturbance in recent memory seen in alcoholics with deficiency of the vitamin Thiamine, but is also believed to be due to direct toxic effect of alcohol on the brain. Some long-term alcoholics develop alcohol dementia due to cortical atrophy. Cortical atrophy, or shrinkage of the brain tissue, is the same pathological finding seen in Alzheimer's disease, and produces profound memory problems. Anosognosia is organically caused denial and is seen not just in stroke and traumatic brain injury, but in these diseases mentioned. It is a symptom of injury to a particular part of the brain, and it is not caused simply by poor memory.

The alcoholic patient that was on the detox unit appeared totally unaware of the gravity of his illness even after "undeniable" evidence was given to him. This inability to recognize his deficits had all the attributes of anosognosia. Alcoholism and chemical dependency are brain disorders. At some point psychological denial may give way to organic unawareness or anosognosia. If a patient's denial seems so strong that it is almost palpable and seems organic, it may be!

THE ELEPHANT IN THE EXAM ROOM

Look, as doctors we all see alcoholics, but we usually don't address that problem in our patients. Hardly any of us had courses or training in medical school or residency to help us know anything about alcoholism. Besides, it's a lot more dramatic and awe-inspiring to deliver babies, do surgery, treat infections, or diagnose other illnesses.

Alcoholism is a self-induced illness to some degree, and the patients with it are resistant, have denial, and, in the early stages, don't want our help. In fact, they may get insulted and never come back to see us if confronted with "you might have a drinking problem."

TIP: About 15% of the population can't control their drinking.
So, what's a doctor to do? Well, you can go ahead and ignore the primary problem and sew up the cut caused when the drunk fell and hit his head; treat the trauma from the drunk driver's car wreck; give more medication for the unremitting GERD or hypertension; add another psychotropic medication to the continued anxiety and depression; and/or you can address the underlying problem.

TIP: Alcoholism causes hypertension, GERD, many GI problems, and anxiety and depression.
If you look at alcoholism as a chronic disease, often genetically determined, then you won't be so judgmental or disdaining of the alcoholic's plight. To address the problem is to talk about it, and that can only be done in a matter-of-fact way without moral judgments, so it can be accepted by the patient.

A little alcohol actually might be good for health, but too much is definitely injurious to every organ system (not just the liver), and is a progressive problem. Alcoholics can't drink just a little, as "one is too much and 1000 is not enough." Alcoholics can't <u>safely</u> drink any.

How much is too much to drink for the non-alcoholic? The Brits say no more than 21 drinks per week for males, and no more than 14 per week for females, with two days per week being alcohol-free. (This may be a bit high, however.) You must define "a drink", however, because I once had a patient who drank three drinks per day but I found out "a drink" for her was an 8oz glass filled with vodka and one ice cube. One glass of wine, one bottle of beer, and one shot of liquor contain about the same amount of ethanol, and each would equal "a drink."

TIP: Females don't metabolize ethanol in the gut, so more gets into their bloodstream.
In the public ER around 85% of problems coming through the doors are alcohol or drug related, while in a more middle-class or suburban ER the percentage is about 50-60%. Gastroenterologists see a lot of alcoholics as alcohol is very caustic to the whole GI track, and alcohol increases the risk of cancer of the esophagus, stomach, and intestine. Internists see plenty of alcoholics with hypertension, liver problems, and pancreatitis. Orthopedists fix the fractures of alcoholics and chemically dependent people caused by their risky and out of control behavior. Psychiatrists have a high percentage of chemically dependent people in their practices trying to self-medicate or suffering from anxiety and depression caused or aggravated by alcohol and drugs. Family practice doctors may wonder why it's so difficult to control a patient's diabetes or hypertension when alcohol may be complicating the whole picture. We all see alcoholics, and our therapeutic results will be much better when treating diabetes, hypertensives, anxious and depressed patients, and others if we can address the primary problem or the complicating problem which is often alcohol.

Laboratory work can help sniff out an alcohol problem. On a CBC elevated MCV and MCH plus low platelets can point to a drinking problem. Elevated AST and ALT can of course point to liver problems and, remember, the GGT is more sensitive and goes up before these more standard liver function tests. An elevated GGT plus elevated MCV and MCH is almost always due to too much alcohol. If such lab abnormalities come up, and even if they are only slightly abnormal, it is best for the patient if the doctor talks to him or her with concern. And because alcohol problems are progressive, these abnormalities should concern the doctor. This is an opportunity for the doctor to address what may be the primary problem or at least a complicating one.

TIP: Elevated GGT +Elevated MCV +Elevated MCH = Alcohol problem

If you suspect an alcohol problem because of certain physical or lab findings, or because usual medications or remedies aren't working, the first thing to do is inquire about drinking. Most people can't tell you how much they drink, so it is helpful to ask the patient to keep track of their drinks per day on a calendar. It might help to ask a spouse or partner to help with this. See the patient back in two or three weeks and then try to ascertain if drinking is a problem If so, then set a goal with the patient to cut down to a more healthy level. Keep track again, and try to achieve the goal. If the patient is successful with this, then your therapeutic efforts and results will be much better, medications can work, and you will do a better job for your patients.

TIP: AA meetings can be found by calling 1411 or on the Internet.

If the patient can't cut back then they may be alcoholic or at least be a problem drinker. You may have to revise your therapeutic plans, but do not be afraid to refer the patient to AA, to a specialist in addiction medicine, or a chemical dependency counselor. Better therapeutic results will definitely come if we don't ignore the elephant in the exam room.

HOW PHYSICIANS HAVE CONTRIBUTED TO THE PRINCIPLES OF ALCOHOLICS ANONYMOUS

By William Loving, MD, ABAM, and Ulysses McLester, CADAC

Formed by a small group of alcoholics in the 1930s, Alcoholics Anonymous is devoted to the rehabilitation of alcoholics. This amazing fellowship has grown into a multinational network of thousands of chapters of AA. The organization has flourished even though it has never had a centralized president or leader, nor has it had a centralized treasurer or budget. It has grown because its concepts are sound and the need for such a group is great.

What most physicians don't realize about Alcoholics Anonymous is the fact that their profession has made major contributions to the establishment of the group. In fact, without their input there would essentially be no Alcoholics Anonymous today.

The first major contribution made to the development of Alcoholics Anonymous was by a physician—William Silkworth, M.D. Dr. Silkworth, as the director of Townes Hospital in New York City in the early 1930's, found that alcoholics seemed to undergo an allergic type reaction when consuming alcohol. They would have an abnormal reaction to the consumption of alcohol and also develop a craving for it. Most alcoholics realize they don't consume alcohol like other people; this "allergy" which is an abnormal reaction to food or substance, is exactly why they cannot drink like their normal peers. This observation still astounds the average drinker.

Dr. Silkworth elaborated on this concept of the allergic reaction to alcohol by saying that the alcoholic cannot safely use alcohol in any form at all. Consider the statement *"cannot safely use alcohol in any form at all."* Many people, both professional and non-professional, often tell the alcoholic he cannot drink, and the alcoholic will simply turn to them and say "bring your money and let's check that out." The alcoholic knows he can drink but what he doesn't realize is that he cannot *safely* drink without developing a craving and getting out of control with alcohol. The first vital piece of information given by the medical world then, was that the alcoholic had a type of "allergy" to alcohol and in fact, the alcoholic had a different chemical or physiological reaction to this substance than the normal person.

Dr. Silkworth's second contribution to the development of the AA principles was that not only did the alcoholic have a disease of the body, but also an "obsession of the mind." An obsession of the mind is an idea or thought that overrides all other valid information. Once the alcoholic began to think about drinking, even though he knew he could not safely drink, he would drink. Once he started drinking, he would re-activate the craving and become out of control with alcohol. Dr. Silkworth didn't know the cure for this allergy and this cycle through the obsession of the mind. But from observations of the many alcoholics he had treated, he knew that a small percentage of these people could abstain from alcohol if they made a very profound change in their personality, or underwent an entire "psychic change," as he put it.

A further contribution regarding alcohol and alcoholism came from Carl Jung, M.D. He knew that the alcoholic must have a spiritual change to overcome the obsession of the mind. Such a statement was a very radical departure for a psychiatrist of his reputation to make. Dr. Jung based his observations on his work with an alcoholic man by the name of Roland H. He had been analyzed by Dr. Jung for a year, hoping to find the basic cause of his alcohol problem. After a year of treatment, learning all he could possibly learn about the workings of the human mind, Roland knew it would be impossible for him to drink again, but he did drink again. Baffled by this action of his, he returned to Dr. Jung to ask if there was any hope for him. Dr. Jung told him no, that he would probably die of alcoholism. If he wanted to live, it would be necessary to place himself under lock and key. At Roland's insistence, Dr. Jung did let him know that there was a possible solution, and that would be a spiritual experience. Dr. Jung described this spiritual experience as one which involved a huge emotional upheaval and

replacement of ideas, emotions and attitudes. He had observed this previously in a few alcoholics he had treated, and knew of a few cases where patients had pulled themselves "up from the gutter," and had returned to become leaders in their social sphere. He noted that these people had changed their ideas, faced their emotions, and adjusted their attitudes in a very profound way. Once this had taken place, a type of religious or spiritual conversion was seen in these people. It was usually found and observed in the confines of the church, even though the church did not usually want to become involved with the conversion experience of the alcoholic. This spiritual change was somewhat analogous to Dr. Silkworth's "psychic change." Dr. Jung noted that "alcohol" in Latin is "spiritus," and "the same word is used for the highest religious experience as well as for the most depraving poison." His prescription for this problem then was "spiritus contra spiritum."

The two major contributions from the medical world were: 1) the alcoholic basically has an allergic response to alcohol, and 2) to recover from it, the patient must undergo a profound psychic or spiritual experience.

Based on these two vital pieces of information, the Twelve Steps of Alcoholics Anonymous were written. The first step dealt with the information given by Dr. Silkworth which stated the alcoholic is powerless over alcohol, and his life becomes unmanageable because of the allergy of the body and the obsession of the mind. The allergy and obsession acting together create a person who is powerless over alcohol. "I have a body that says I can't drink and a mind that says I want to drink." When these two premises conflict, the mind always wins, and the person drinks again. The solution is Step Two of the Alcoholics Anonymous program, i.e., "come to believe that a power greater than ourselves would restore us to sanity." Once a person will admit to himself that he alone cannot do anything about this powerlessness and that a power far greater than himself is necessary to help him, there is some hope. The third step of Alcoholics Anonymous deals with a crossroads…"which do I choose…which decision do I make…to continue the old way or to begin a new way?"

The remainder of Steps Four through Twelve is simply to help a person attain this spiritual or psychic experience. By virtue of this experience, the alcoholic begins to change his ideas, emotions and attitudes. Once this happens, he has an entire psychic change or spiritual experience sufficient to overcome drinking. It is very important that the medical world claims its contributions because without them, the alcoholic never would have known what this problem really involved or how to obtain the solution.

Written by William M. Loving, M.D. and Ulysses McLester, CADAC.

FOOTNOTES 1 *Alcoholics Anonymous Big Book*., 2. *"Pass It On"* and the Bill W. / Carl Jung letters., 3.*Not God.*

BOTTOM UP

It is said “that alcoholics and addicts don’t get help until they hit bottom.” Families of these patients feel very helpless and suffer a great deal while they watch their loved one sink to this bottom. It’s not so agonizing for a “high bottom” alcoholic or addict because something as small as a cross word from a spouse will drive them to seek help or treatment. “Low bottom” patients however may lose virtually everything in their life and end up literally eating out of dumpsters before they seek help. Doctor’s have a valuable opportunity to help by bringing the bottom up to their patients so that they will get help before they have lost everything.
Did you know that alcohol and drug problems are involved in:

- 60%+ child abuse
- 60%+ fatal car accidents
- 50% of drowning
- >50% of accidents and family violence many medical problems and ER visits
- 33% of fatally injured bicyclists have elevated BAL

The problem is so big that we cannot see it and then under react to it. The use of alcohol and drugs is quite engraining in our culture and goes along with a natural human desire to have a shortcut to happiness; have control over our feelings; and have a method to shut out unpleasant and difficult parts of reality. The use of chemicals (especially alcohol) has been with man for centuries and probably started the first time a caveman tasted the sweet smelling liquid left behind from a bunch of fermented grapes he had left on the ground. Alcohol and drugs are here to stay, as are the problems that directly affect almost 20% of our population. These people get out of control with one of the chemicals that make them “high” or change the way they feel. Tolerance and dependence sneak up on them, compulsive use continues despite harmful consequences, and attempts to quit become futile. No one uses these substances to get DWIs, make a fool of themselves or cause problems at home or on the job. This is a self-induced central nervous system disorder but overtime the “self induced” part becomes less and less volitional. The end organ for drugs that make a person “high” is the brain and so judgment and insight are significantly affected and the patients become unable to identify their problem even though it may be obvious to everyone around them.

The most effective way to treat the alcoholic or addict is to view the problem as a chronic disease, not as a willpower or moral problem. These patients become truly out of control with their drug of choice to the point that willpower cannot overcome the problem. Research shows that the etiology is multi-factorial but genetic and biological factors are a significant part of the problem. Strong evidence shows that 18% to 20% of our population directly affected has a physiologically different reaction to alcohol and addictive drugs than the average person. They are more strongly affected by the drugs (get “higher”) and are more likely to become dependent. These people have a type of “allergy” and the best treatment is total abstinence.

Chemically dependent people need treatment similar to treatment for any chronic or relapsing disease. As in any chronic disease the patient has difficulty accepting the diagnosis and tries to deny and rationalize away the problem. Education is fundamental to the treatment because there is no cure and the patient must be taught to manage the illness just as diabetics and asthmatics are taught to manage their illnesses. Fortunately Alcoholics Anonymous and Narcotics Anonymous (AA and NA) are active, effective, and free groups that provide not only support but also a step wise plan of recovery. The only reason these 12 Step programs have survived since inception at around 1937 is because they are helpful and work. No one profits financially from AA; there are no marketing directors or missionaries; and yet these programs have spread all over the world with Austin alone having more than 50 meeting sites. The 12 Step program is a valuable tool for the patient to use to recover from this devastating illness. Treatment programs help patients learn to use this valuable tool properly while understanding important fundamentals and ignoring the sometimes annoying insignificant sides of AA and NA.

In the early stages of recovery the patients feel and look mentally disturbed to some degree and about 20% of chemically dependent patients have true psychiatric problems (depression or anxiety disorders primarily). Some patients will need a psychiatric evaluation and some will need medical care. Secondary medical problems such as pancreatitis, liver disease, HIV and many other physical problems are common and need to be addressed. Doctors in all specialties have some patients with drug and alcohol problems causing or complicating the disease for which the patient is coming to the doctor's office. Most doctors have little education or interest in the disease of alcoholism and chemical dependency.

What can the doctor do if a chemical dependency problem is suspected? The doctor should discuss these concerns with the patient in a direct and non-judgmental way. For example, an internist knows his patient drinks and then finds on lab work that the MCV and GGT are elevated plus the physical exam shows slight liver enlargement and elevated blood pressure. This patient has an alcohol problem. Rather than minimize the mildly elevated GGT and physical signs the doctor should take the opportunity to talk to the patient about these abnormalities in the most negative of terms. It even helps to show the patient the lab values and to really emphasize the abnormalities and the dangers. This is the time when the doctor needs to help the patient be appropriately fearful of the true dangers to come such as cirrhosis, if they do not stop drinking. This is what I mean by "bringing the bottom up to the patient." The doctor has a golden opportunity to help the patient seek treatment or help before sinking to a "low bottom." We should use this opportunity and our power in the patient's best interest.

What follows is a "cheat sheet for doctors" to give some useful clinical information and tips to help with diagnosis. Also included is a patient handout sheet that can be copied and given to

the patient you suspect has a drug or alcohol problem. This handout also contains local referral sources and ways of finding out where AA and NA meet.

THE MYTH OF MARIJUANA

When I admit a new patient to the hospital (an inpatient chemical dependency and dual diagnosis program), I do an evaluation and ask a lot of questions about substance abuse. The new patients come here because they are out of control with drugs and/or alcohol, usually need medical detoxification, and also need rehabilitation to change the way they are living. To detoxify them safely I need to know what drugs they are using, how much and how often. The drugs are cocaine, methamphetamine, opiates (heroin, oxycontin, hydrocodone, etc.), benzodiazepines (Xanax, Klonopin, and others including Soma), hallucinogens, alcohol, and last but not least – marijuana. The patients are quick to identify their problem when it is shooting heroin daily, smoking $100 of crack per day, drinking a fifth of whiskey per day, or taking 30 Vicodin a day. I always ask “what else?” or “how much?” several times because most underestimate their amounts, and many are using 2 or 3 different drugs. When I ask, “Do you smoke pot?”, 90% answer “yes.”

In going back through the patient histories, 85% started their drug use with pot and the other 15% started with alcohol. Marijuana is usually their first experience with a chemical high, and many move on to various other drugs searching for a stronger or better euphoria. If I don’t ask specifically “Are you smoking pot?” most will not mention it because they take it for granted, as they have usually been smoking since age 10, 11, or 16. They haven’t looked at it as the problem, but rather as a given in their life. It’s easier to see cocaine or alcohol as problems because behavior is disinhibited and dramatically out of control, involving car wrecks and fights. Marijuana is not so dramatic and in fact it causes people to sit on the couch, watch TV, and eat. How can that be a problem?

Well, marijuana is a problem - a big problem - for the patient and society, yet denial in our society and in the individual patient is huge. In our culture today many people say things like, “It’s not addictive”; “It’s natural and so it’s okay”; “It just mellows me out”; and “I can keep smoking pot, I just need to quit the dangerous stuff.” It’s so common for patients to continue to stick with marijuana use after treatment for addiction, that clinicians have coined the term “marijuana maintenance program” for this misguided recovery plan.

Besides working in an inpatient chemical dependency program, I am a psychiatric consultant for an adolescent residential treatment center. 98% of these patients start with marijuana (usually called “weed” these days), and end up in the program because while on probation for truancy, possession, or petty theft, they repeatedly test positive for marijuana on their probation officers’ drug screens. They can’t quit smoking even when monitored. These

adolescents and the previously mentioned adult patients do not think they are addicted even though they smoke daily - sometimes for years. None believe they will become addicted to marijuana or get out of control with other substances.

Marijuana has an inaccurate reputation that it is not addictive because there is not a significant physical withdrawal syndrome when it is stopped. When alcohol is stopped abruptly, visual hallucinations, tremors, seizures, or DTs will occur. Stopping opiates abruptly causes an intensely uncomfortable flu-like syndrome. To avoid these withdrawal problems we give a cross tolerant drug and taper the patient gradually off of that detoxification medicine. Marijuana has a built-in taper when stopped abruptly. Because THC (the active ingredient in pot) is stored in the fat cells and because fat cells have such poor blood circulation, THC is slowly released from the body over a few weeks. This becomes a natural, undramatic withdrawal and explains why marijuana cessation does not cause a lot of physical discomfort. But, just because no withdrawal syndrome occurs doesn't mean it is not addictive. Addiction is compulsive use and obsession with the drug. I have seen many patients who smoke every day, even though problems and losses pile up; they don't get high like they used to; and even though they get anxious and paranoid when they smoke – they still use. This is addiction.

Some people distinguish between "psychological" and "physical" addiction. Addiction is both psychological and physical. Marijuana is addictive but because of the built-in taper with this drug, people have a hard time believing it. Just like other addictive substances, not everyone becomes addicted. Denial is particularly strong with marijuana users, and society's attitude strengthens this denial.

The harm marijuana causes is passive rather than dramatic, and comes from what this drug takes away. All of the experts agree it causes the amotivational syndrome and decreases memory. Recently, I attended a family group session involving 15-20 likeable and hard-working parents of pot smoking teenagers. All of the parents said they were against their teenager smoking marijuana, but half of the parents were pretty soft on the issue. These parents had the attitude "teenagers will be teenagers," "everybody does it," "it's not addictive," and "look at me, I smoked through school and it didn't hurt me." One said, "I smoked all through college, it was the best 8 years of my life." Isn't college supposed to be 4 years? All of these parents are also encouraging their kids to make good grades, work hard in school, aim toward college, and enter a good profession. Passively condoning marijuana use works in the exactly opposite direction.

Many of these parents smoked pot 20 or 30 years ago when the marijuana was about 1/5th as strong as today's "weed." The product has been "new and improved." Kids also tend to start smoking earlier in their lives. It's not unusual for children to start in middle school or the early teens. Just as any salesman has new and improved products; dealers also have access to a variety of other products. Where pot is bought many dealers also have stronger and different drugs like Xanax "bars", "oxy", cocaine, etc, etc. If a person really likes the vanilla ice cream,

it's not long before cookies and cream ice cream, sorbet, or sundaes are tried. Some people pooh- pooh the term "gateway drug," but once a person likes getting high, it is natural to move on to "the better stuff."

A percentage of drug and alcohol users (about 15-20%) will go on to true addiction. The majority won't become addicts or alcoholics, but the harmful effects of marijuana affect all who use. The 15 year old who is smoking has lower motivation, becomes more withdrawn, and doesn't concentrate or remember as well. This interferes with achievement and with development. The brain isn't fully developed until age 24 or 25. This drug that profoundly affects the brain and neurotransmitters especially causes big problems in the developing brain. Richard Hawley says in his book, *The Purposes of Pleasure*, that "not only does marijuana change the personality, but what's worse it changes the thing that makes personality—the brain." Marijuana use in the teenage brain may cause irreversible changes and losses.

When a young person learns he or she can get high by just ingesting a substance they tend to not learn the valuable things natural highs (non-chemically induced) teach us. Natural highs teach us mastery, problem solving, stress management, and make us healthier and happier human animals. Self-esteem is increased with these pleasures and coping skills. Highs from marijuana and other drugs teach us nothing, and decrease self-esteem along the way. Emotional and psychological growth is short-circuited by marijuana and other drug use. In the short run the chemical highs seem like a great deal, but in the long run they are terrible deals. Marijuana is one of the most dangerous of drugs because it has such a benign reputation, and yet takes away so much from our young people. It "dumbs down" our youth and our society, and the myth that marijuana is "not a big deal" is just that – a myth. In American we will either have to greatly lower our expectations of future generations, or take off the blinders and admit that marijuana is a very dangerous drug.

DOCTOR'S CHEAT SHEET FOR ALCOHOLISM & DRUG DEPENDENCE

By William Loving, MD, ABAM "Clinical Rounds", *Travis County Medical Society Journal*, May / June 2001

- Chemical dependency begins with abuse and is characterized by tolerance, compulsive use despite harmful consequences, and persistent futile attempts to quit.
- End organ of all substances of abuse is the brain. Therefore, expect symptoms/signs of dysinhibition, poor judgment and insight, moodiness, poor communication, dysfunctional relationships, neurological signs (decreased balance, decreased coordination, etc.)
- Psychologically expect denial and rationalization.
- Dangerous withdrawal possible from alcohol, benzodiazepines, and barbiturates (opiates cause very uncomfortable withdrawal).
- **Tips a problem exists:** Blackouts, DWIs, arrests, fights at home, ER visits, emotional irritability, medical problems related to the drug or route of administration.
- **Tell tale lab:** Elevated MCV and GGT = likely alcoholic (also increased AST and ALT)
  Decreased platelets = may be alcoholic
  Positive HIV and abnormal liver function test may mean IV drug use
- **Physical signs:** Enlarged liver, "track" marks, jaundice, signs of trauma, excoriated nasal membranes, elevated blood pressure, abnormal neurological signs, spider angiomata, seizures, chronic cough, pinpoint pupils.
- Cocaine associated with seizures and arrhythmias. Opiates associated with "track" marks, pinpoint pupils, increased pain medication seeking. Marijuana associated with amotivational syndrome.
- **CAGE –** 1 or 2 positive answers indicate an alcohol problem (works for drugs too)
  - Have you felt the need to **C**ut down on your drinking?
  - Have you been **A**nnoyed at others who criticize your drinking?
  - Have you felt **G**uilty about your drinking?
  - Have you had an **E**ye opener or a drink in the morning to calm you or help a hangover?

- **FOY –** Has your **F**amily, **O**thers or **Y**ou been concerned about your drug or alcohol use? (one or two positives)
- **How much is too much alcohol?** In Britain the recommendation is for no more than 21 glasses of wine or beers per week for males and no more than 14 for females with 2 drink free days per week. In my opinion this is too much. (Females reach higher BAL due to lack of alcohol dehydrogenase in the gut lining.)