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## **Recovery-focused Addiction Psychiatry: An Interview with Dr. Marvin Seppala**

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### **Abstract**

In 2012, Hazelden, the iconic exemplar of the Minnesota Model of chemical dependency treatment, announced its decision to begin using naltrexone and buprenorphine as optional adjuncts in the treatment of opioid addiction. This shift in clinical philosophy at Hazelden garnered considerable professional and public attention. At the center of the ensuing debates was Dr. Marvin Seppala, Chief Medical Officer of Hazelden Betty Ford. This interview conducted with Dr. Seppala December 2015 explores his career as an addiction psychiatrist and discusses numerous issues related to the treatment of addiction, including the 2012 decision on medication-assisted treatment and how medications are being effectively integrated into 12-Step-oriented addiction treatment.

Keywords: Addiction psychiatry, addiction medicine, Hazelden Betty Ford, Minnesota model, medication-assisted treatment.

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### **Introduction**

Hazelden, the most iconic of 12-Step-oriented treatment programs in the United States, announced in November 2012 its decision to begin using medications (naltrexone and buprenorphine/naloxone) as an optional adjunct in the treatment of patients seeking help for opioid addiction. That decision may well represent a tipping point in the history of medication-assisted treatment of addiction in the U.S. As might be expected, this decision stirred professional controversy and considerable media attention. At the center of the decision and subsequent national discussions was Hazelden Betty Ford's Chief Medical Officer, Dr. Marvin Seppala. In December 2015, I interviewed Dr. Seppala about his life's work, his experience with the introduction of medication-assisted treatment at Hazelden Betty Ford, and the future of addiction treatment. Dr. Seppala has one of the most riveting personal/professional stories I have encountered in the addictions field. Join us in this discussion of his life and life's work.

## Personal Background

**Bill White:** Dr. Seppala, you followed a most interesting personal pathway into the addiction treatment field. Could you briefly share that story?

**Dr. Marvin Seppala:** I don't know how brief I can be (Laughs), but I'm glad to do that, Bill. As a seventeen-year-old high school dropout, I ended up in treatment at Hazelden in 1974. I learned five years later that I was the first adolescent they ever treated. I went through the first two weeks arguing that I didn't belong there, but then figured out that they were right: I had this disease that they then called chemical dependency. And yet, I only was able to maintain abstinence for five days after leaving treatment. There was absolutely no follow-up then other than to go to AA, and I lived in a small town in Southern Minnesota that had no AA. Eleven miles away in Rochester, Minnesota, there was plenty of AA; I just didn't pursue it.

They got me back into high school, and I went through the graduation ceremony without a diploma, but that summer, I was kicked out of the house and disowned by my family because of my relapse. I ended up going from job to job unable to maintain anything for any length of time. Late that summer, I applied for a job at the Mayo Clinic as a janitor. I figured that was the only thing I could do, and I lied on the application by telling them I'd graduated from high school. They didn't have a janitor's job and sent me on my way, but two weeks later, they contacted me through my girlfriend. (I was living out of my car and had no phone.) They told me that they wanted me to come by for an interview, so I assumed I had a janitor's job. Instead, I was hired to work as a lab technician in a cardiovascular research lab. This was all something of a miracle—first going into Hazelden and then getting this job. It turns out that I worked under two world-famous cardiovascular researchers. One of them, John Shepherd, was the President of the American Heart Association and on the Board of Governors and Board of Trustees at the Mayo Clinic. The other was David Donald, an eccentric Ph.D. veterinarian researcher who helped invent the heart lung machine. People came from all over the world to do research fellowships in cardiology with these two medical pioneers. The place was just a cauldron of information and innovation. It was invigorating for me from the very first day. I had no idea I was getting into what would be such an incredible experience. Ultimately, it was my fear of losing that job that finally got me to AA and into sobriety in Rochester, Minnesota.

No one in that lab knew about my addiction. I didn't dare tell anyone. It was actually a surgical lab, so we had all kinds of drugs available, none of which were documented or maintained in a way that you could tell if any were stolen. We were, for example, studying cocaine and its effect on venous smooth muscle. It was an odd place to get sober, but I did. And when I later got a medical license, it really didn't matter to me to have the privilege to prescribe medications. It wasn't a risk to my sobriety because I'd already worked in the candy store. These two influences—the spirituality of Twelve-Step recovery and medical science—have been the two most enduring influences on my life.

**Bill White:** At what point did you make the decision to return to school?

**Dr. Marvin Seppala:** I honestly had lost all vocational interests through my use, completely abandoning the idea of going to college. After getting sober and while working in the lab, these

world renowned physicians kept asking me what I was going to do with my life. They suggested I go to college and my teachers from high school had allowed me to come into their homes during the evenings on weekdays and finish my schoolwork. That gave me my high school diploma. My diploma was just like anyone else's and I later saw that my high school transcript failed to show that I had missed four months (laughs) and that I had graduated late—a remarkable gift to be able to go in to my teachers' homes like that and then to have a pretty clean transcript.

Another quirky influence was working in that lab and one day receiving an interdepartmental envelope in the mail that was addressed by mistake to “Dr. Marvin Seppala.” I looked at it and crystallized what I had been thinking. I told my sponsor, who knew me as a high school dropout, “I gotta go to college because I want to be a doctor.” (laughs). He had no clue as to whether this was reasonable, let alone rational, but he said, “You know, Marv, if that's God's will, it'll happen.” That was exactly what I needed to hear because that put it in a context that made it possible, but also put it in my lap. I decided after two years in the lab to go off to college and then to medical school. That was my intent, doors kept opening, and I was able to pull that off and actually return to Mayo to go to medical school.

## **Medical Training**

**Bill White:** When you made the decision to enter medical school, did you do so with the intention of specializing in psychiatry or addiction psychiatry?

**Dr. Marvin Seppala:** No, I was planning on becoming a cardiac surgeon just like this Brazilian cardiac surgeon in the lab who influenced me to go into medicine. In the lab, we were doing surgery on animals, and he would ask me to assist him in surgery. He would tell me these incredible stories of healing back in Brazil that inspired me to want to follow in his footsteps. I was going to be a cardiac surgeon until about two years into medical school. During clinical rotations, I recognized alcoholism and addiction everywhere I did hospital rounds. I was attending a particular 12 Step meeting at the time that had a couple of physicians, and I regularly complained about the failure to identify and treat the addictions underlying the presenting medical disorders. After several weeks of this, the two physicians took me to the side one day and said, “Marv, you have got to quit bitching about this and do something about it.” It was then that the possibility of specializing in addiction first entered my mind. I started looking at options to specialize in addiction, and it just felt so right, and it interested me so much. After talking with several people, I decided to pursue psychiatric training and to specialize in the treatment of addiction. Interestingly, when I told one of the attending physicians at Mayo that I was going to go into psychiatry and specialize in addiction, he said I was throwing away a good career in medicine.

**Bill White:** Was that kind of attitude pervasive within your medical and psychiatric training?

**Dr. Marvin Seppala:** It certainly was in my primary medical training. No one could believe I actually wanted to work with addicted patients. Psychiatry was not regarded as a true medical specialty, and addiction was not even thought of as a disease.

**Bill White:** When you did your psychiatric residency, was there much focus on the treatment of addiction?

**Dr. Marvin Seppala:** Yes, at that time at the University of Minnesota, there was a great deal of interest in addiction and its treatment. There was an addictions department with addictions treatment services (primarily outpatient), and at the Minneapolis VA, there were both residential and outpatient services. The University of Minnesota actually operated a Southeast Asian Opium Clinic. After the Vietnam War, the Lutheran Church sponsored a lot of Vietnamese people to come to Minneapolis. A lot of Hmong folks had grown and used opium in Southeast Asia and brought it along with them. There were opium dens all around the Twin Cities at that time. Dr. Joe Westermeyer, a remarkable teacher who was running the U of M addiction department, opened the Southeast Asian Clinics. I had a broad experience of addiction treatment throughout my residency and then even more so during my addiction fellowship with Joe Westermeyer. Mark Willenbring, who later went to NIAAA, was also there at the time doing addiction-related research. It was a great place to be during those years (1984-1988). I was exposed to all kinds of alternatives to the Twelve Steps that really stretched me and forced me to look at diverse ways that people get sober. *The Natural History of Alcoholism* had been published by Dr. George Vaillant, which gave me another way of looking at this disease and to recognize that the way that I got sober wasn't necessarily the way everybody got sober. It was an incredibly stimulating environment and, although we examined the various ways in which people got sober, my own recovery was accepted and honored.

### **Early Work in the Field**

**Bill White:** When you finished your psychiatric residency, what were some of the early positions and consulting roles you held?

**Dr. Marvin Seppala:** I had to work multiple part-time consulting jobs per week because no one was really hiring addiction physicians full-time at that point. I worked part-time at an adolescent treatment center, a women's treatment center, and a dual diagnosis inpatient hospital. I worked at a couple halfway houses providing psychiatric care. I worked in a staff model HMO at one point, and I worked in a Native American treatment program for a while. It was difficult to go to so many places per week, but I really got a lot of experience fast and learned a lot about addiction treatment options.

**Bill White:** Were there lessons from that early period that informed your later work with Hazelden?

**Dr. Marvin Seppala:** Absolutely. All of this work opened my eyes to other ways of doing things than what I had experienced in my own treatment at Hazelden or my training at Mayo and the University of Minnesota and exposed me to the tremendous passion that so many people bring to their work in this field. These roles also sharpened my understanding of the ways in which psychiatrists could contribute to addiction treatment. I was often the only mental health person in these settings so I would be sent people with all manner of trauma and a wide array of psychiatric illnesses. In the HMO system in which I worked, I was the only person doing dual diagnosis care in the whole system. The addiction counselors and psychiatrists both referred

people to me with co-occurring disorders. I learned a great deal and rapidly gained comfort and expertise working with such complex situations. I was able to figure out ways to enter into discussions within these diverse settings to get the best possible care for each patient. I found people very receptive to the help I could offer using knowledge of both recovery and psychiatry to individualize care. I also had the benefit of training and experience in cross cultural aspects of addiction and psychiatric illness; another way to individualize care. I learned a great deal about relapse and the limited outcomes associated with all types of addiction treatment, helping me to understand the true complexity of this disease. The limited research in the field was often unhelpful in determining how to plan treatment for the patients I was working with. So at the time, we had poor outcomes and lacked established means to improve upon outcomes. These influences forced me to learn as much as I could from the literature and from those I worked with, to put into use in innovative, creative ways in hopes of helping those who needed more than they were being offered.

**Bill White:** I would suspect you also developed a vision of what an ideal integrated system of care would look like that addressed both issues.

**Dr. Marvin Seppala:** I did. I thought about that a lot over the years and looked forward to a time I could apply what I was learning. I was later able to do that at Hazelden Betty Ford.

### **Hazelden Times Three**

**Bill White:** Tell the story of how you came to serve as the Chief Medical Officer at Hazelden Betty Ford Foundation.

**Dr. Marvin Seppala:** Well, I've done it three times, and strangely, I'm the only person that's served in this role. From 1990 to 1993, I was a psychiatric consultant at Hazelden Pioneer House, which later was rechristened Hazelden Center for Youth and Family and currently is known as Hazelden Plymouth. It's Hazelden Betty Ford's adolescent, young adult program. I went once or twice a week to provide psychiatric consultation. I hoped to do more with Hazelden but that did not happen at that time. So, my wife and I decided we would move back out to Oregon where I'd been right after I finished my training. Shortly after getting to Oregon, I got a call from someone at Hazelden letting me know that they were finally going to hire a Medical Director and that they would like me to apply. I applied and after nine months was notified that I got the job. I then found out that they had no idea what to do with me or this position. I only lasted nine months. They didn't know why they hired a Medical Director. They didn't know how to use me as a Medical Director, and I wasn't really integrated into the system well. It was very disappointing, but the organization was not ready for physician leadership.

So I left and returned to Oregon. There, I consulted at Springbrook Northwest, which was a treatment center outside of Portland, Oregon, until it was sold to Hazelden. At that time, the President of Hazelden and I talked, and he hired me again as the Chief Medical Officer. I did that from 2002 through 2007, at which point I had a disagreement with the new CEO in regard to how treatment should be provided—the tension between quality of treatment versus revenue. I left for a couple of years and started an outpatient treatment program in which I gained a lot of experience with the treatment of opioid dependence using buprenorphine/naloxone, commonly

known as Suboxone. In 2009, I got a call from the assistant to Mark Mishek, the current CEO of Hazelden, who asked if I'd go out to eat with Mark and his wife when they came to Portland for a visit. Halfway through the meal, he offered me my old job back. So I became the Chief Medical Officer for the third time and have been there since. It is a tremendous job and I'm surrounded by really talented people. I have the support of the CEO and the Board. I don't believe there exists a better job for me.

**Bill White:** How would you describe just the experience of working with one of the most iconic addiction treatment institutions in the world?

**Dr. Marvin Seppala:** That's a tough question. We have tremendous resources for the treatment of addiction, which is our primary focus. We are a very organized, large, and diverse system with treatment, publishing, public advocacy, prevention, and education programs. Our leadership team is outstanding. We live our values at Hazelden Betty Ford. We were founded on treatment provided with dignity and respect. Integrity is essential to our ability to function. In many ways, my experience here is much like that at Mayo; the resources are exceptional, the staff is tremendous, you are expected to perform at the highest level, and the primary focus is on exemplary patient care. There are extremely high expectations for the quality of care that we provide, but in the past, we had become quite parochial. Hazelden Betty Ford stood on its laurels without feeling the need for continued innovation. The attitude was, "We know what we're doing and don't need to change." In recent years, at least the last five or six years, that has completely shifted. I think we are shaking things up again to provide the highest quality of care we can for people with addictions. Hazelden Betty Ford leadership is now singularly focused on providing the highest quality of care. If I had to summarize my job, it would be, "How can we improve the long-term recovery outcomes of every patient that comes to Hazelden Betty Ford?"

**Bill White:** Wow, what a job description. Could you elaborate a bit more on how you've seen the treatment philosophy and methods evolve since your initial work with Hazelden?

**Dr. Marvin Seppala:** When I look back at 1974 when I was in treatment, we've come from using the "hot seat" in groups to now offering the very latest treatment medications. We've gone from a sub-acute care model of four weeks of treatment and go to AA to a real examination of treating addiction as a chronic illness over the lifespan—a sustained recovery management orientation. We have full mental health services. In our adult setting, over seventy-five percent of our patients have a psychiatric diagnosis before they arrive and in our youth setting, it's over ninety-five percent. We've integrated full time psychologists and psychiatrists into our treatment teams, and we continue to have very well-trained addiction counselors. We've used multiple psychosocial therapies for decades, and have moved our focus primarily to CBT and MET. And we've retained our Twelve-Step orientation and an emphasis on the role of spirituality in addiction recovery—all while remaining open to new evidence-based practices that come along.

**Bill White:** Critics of the Minnesota model suggest that the approach represents a "one size fits all" approach to addiction treatment. How would you respond to that criticism?

**Dr. Marvin Seppala:** In the past, I'd say that was a fairly accurate criticism. There was the Minnesota model and it worked well for a number of patients, perhaps even most, but didn't work for others. It was primarily program-based—you walked into this black box, you came out the other side, and you were expected to be better. It provided a framework for recovery, but neglected the chronic nature of addiction. That's not an adequate way of addressing any disease, and certainly isn't in keeping with our current recognition of addiction as a complex, chronic illness. As any field matures, things change, and Hazelden Betty Ford has advanced with the field, even leading some of these advancements. We may have stuck with that black box too long, but we've made great progress in individualizing the care we provide. We currently offer treatment for those with addiction and other mental illness, chronic pain, trauma, and we provide LGBTQ programming. As a possibility in the near future, we are looking to contract with insurance companies to provide services for a whole year in a person's life for a set fee, providing all the care needed by that person to sustain his or her recovery. This will require objective decision making based on data describing the care most likely to result in abstinence and recovery at the lowest cost.

**Bill White:** Which would create an extremely nuanced, highly individualized approach to treatment?

**Dr. Marvin Seppala:** It would and it's very exciting. We have the opportunity to use predictive modeling to individualize care. We have done outcome studies for years on subsets of our patients, but our vision is that clinical and cost outcomes would be tracked long-term on every patient treated at Hazelden. This will provide a database that can help us to predict the best care for people based on the outcomes of others. We will actually be able to determine if the changes we make to treatment improve outcomes or not. Our whole model would drastically shift toward this longer term vision of personalized recovery management. As a psychiatrist, I have worked for multiple organizations and have licensure in multiple states, but no one has ever asked me about my clinical outcomes. That has to change; we need to know if what we are doing is helping and contributing to better outcomes or not. Knowing our outcomes on everybody will allow us to alter the programming in a prescriptive manner to meet the needs of each patient and family.

### **Medication-assisted Treatment at Hazelden**

**Bill White:** One of Hazelden's most controversial decisions was the decision to integrate pharmacotherapy as an option within Hazelden's traditional psychosocial treatment methods. How did Hazelden come to make this decision?

**Dr. Marvin Seppala:** When I was the Chief Medical Officer between 2002 and 2007, we made a decision to start using naltrexone and then acamprosate for treatment of alcohol dependence. When I left the organization between 2007 and 2009, I gained experience using Suboxone with an opioid-dependent population. When Mark Mishek asked me to return to Hazelden, I told him about this experience and my sense that we needed to take Hazelden into a new realm by integrating the option of medication in the treatment of opioid addiction. I knew that there would be some controversy related to this, but I believed it would be of benefit to selected

patients and that such benefit should always be our guiding rod. When framed that way, Mark was supportive from the very beginning. Our Board was also unanimously supportive of this direction, paving the way for such a significant change in programming.

**Bill White:** How would you describe the initial reactions to this decision from everyone from staff and alumni to the larger field?

**Dr. Marvin Seppala:** It was variable, with responses at both ends of the spectrum. Our staff was very curious, and some really questioned our decision. Externally, people were saying that we were ruining AA. They were asking how we could turn our backs on abstinence. There were claims that we were destroying the legacy of the institution and undermining everything Hazelden's ever done for the treatment of addictions. And on the other hand, there were folks congratulating us for integrating the latest scientific advancements into the treatment of addiction. Amidst the personal attacks, there were those simply saying, "Well, it's about time!"

**Bill White:** How have those responses evolved since the initial announcement? And I think, not only the field, but also how the staff attitudes towards this has evolved?

**Dr. Marvin Seppala:** Our staff wasn't sure what to think when we first started talking about moving in this direction. In fact, one of our counselors who's now the Co-Chair with me of this whole project, was quite ambivalent about it and asked me if it was a good career decision to join a team using Suboxone and Vivitrol for the treatment of opioid dependence. Today, we have remarkable support for this move among the staff. When people witness the advantages of using these medications in patients we are treating, they readily get on board, especially when they see the long-term engagement and watch people blossom in recovery. We have had a marked reduction in atypical discharges among our opioid use disorder patients—in fact, a lower rate than in our general population. We particularly emphasize the importance of long-term care for people with opioid dependence. Some of them take a medication and some of them don't. We actually have three different possibilities: no medication, Vivitrol, and Suboxone. All three are together in groups sharing their experience throughout treatment. If you sit in on these groups, you cannot tell if someone is on medication or not, nor which medication.

We are doing a research project because we have to figure out in a predictive manner who needs what and for how long. There are people who recover from opioid addiction with and without medication support. Many recovering physicians have recovered without maintenance medications and some were addicted to the most powerful opioids on the planet. I've known a lot of people who walked into Narcotics Anonymous on their own and achieved sustained recovery without medication. I don't agree with my colleagues who say that everybody with an opioid use disorder needs to be on a maintenance medicine and be on it for life. And I don't agree with those who would deny medication as an option for all patients. We need the science, not personal opinion or ideology, to guide decisions on who should be and who shouldn't be treated with these medications. As a physician, I would like to be able to tell this particular individual and his/her family that this is the best treatment because of these particular aspects of his/her disease and I can't do that at present because we don't have the research to guide such prescriptive, individualized decision making.



**Bill White:** Do you think it's an embarrassment for us as a field that at this late stage of our development, we don't have the kind of outcome data you earlier referenced to guide these decisions?

**Dr. Marvin Seppala:** I think it's an embarrassment for the whole of medicine. Although there are certainly some pockets where this is occurring in medicine, cardiology's doing it, orthopedics is doing it, but in general, that's not the case. If we could do this in the addictions field, we could actually be in the forefront of the direction all of medicine needs to proceed.

**Bill White:** I know that Hazelden is in the process of formally evaluating the different options you have around medication-assisted treatment and that this data will be reported, but I'm very interested just in you sharing what your impressions are to date. Are you engaging patients today who would not have been engaged earlier? Are people sustaining recovery who previously would not have been able to? What are you learning?

**Dr. Marvin Seppala:** I think we've made a real contribution in both those areas. There are people coming into our treatment settings now who would not have come in without having access to these medications. Opioid dependence is very hard to treat and there's a high dropout rate. We continue to lose some people early, but as a whole, we are engaging them longer and with longer engagement comes better recovery outcomes. If we can keep people engaged for at least ninety days across levels of care, they do really well and start to blossom. This is a chronic illness with a substantial death rate. We need to use everything at our disposal to improve outcomes, and we've noted a reduction in overdose death secondary to relapse after treatment. Unfortunately, this issue is not getting adequate attention, and I hope my colleagues continue to focus on preventing this tragedy. We've learned that in long-term care how and why people engage changes over time and we need to listen to our patients and provide services they consistently gain from, or they leave. We also thought that many people entering our system would seek Suboxone, and that diversion and excessive use would be significant problems. Neither has been an issue. In our youth program, many patients refuse Suboxone due to a history of past abuse, or they say it was the first opioid they used for intoxication and can't imagine using it as a treatment. This was a surprise.

**Bill White:** Will the work on medication-assisted treatment that started in Minnesota be extended to other Hazelden facilities, including the Betty Ford Center?

**Dr. Marvin Seppala:** Yes it will. Our plan is to eventually have all our facilities offering this expanded service menu. We don't yet have physicians at all of our outpatient sites, so we're addressing that to expand the option of medication-assisted treatment system wide within Hazelden Betty Ford. Betty Ford Center is already training in regard to this program with plans to implement. There was the same sort of initial resistance to this among the Betty Ford staff that we experienced elsewhere, until they learned about it and saw with their own eyes at some of our other sites how this was working clinically. Now, they are excited to do it as well.

**Bill White:** There was an impression I got listening to critics of Hazelden's decision on pharmacotherapy that all opioid addicted patients would be expected to go on medication. But, in fact, what you've described is really using medication to enhance the potency of all the

psychosocial and spiritual supports that were built in to the traditional model and, at the same time, using those psychosocial and spiritual supports to enhance the power and potency of the medication.

**Dr. Marvin Seppala:** I believe that's a great way of describing it, Bill. From the beginning, we said that we're using the medications adjunctively to the primary treatment for addiction. We are not replacing our other methods with medication; we are offering the option of medication for some patients in combination with those other methods. We think the medications can improve outcomes for opioid use disorders when combined with our robust treatment model and that most people will be able to discontinue medications after getting into solid recovery.

### **Treating Addiction and Chronic Pain**

**Bill White:** One of the key issues in the rise of opioid addiction in the United States has been the wide prescription of opioids in the treatment of chronic pain. What are our options as a field for the concurrent integrated treatment of addiction and chronic pain?

**Dr. Marvin Seppala:** I don't think we have really good models yet. Part of that is because we don't understand chronic pain adequately at a biological level, although that's improving. There are a few places that have been able to integrate good chronic pain treatment and addiction treatment such as the Betty Ford Center, our outpatient program in Beaverton, Oregon, and Las Vegas Recovery. We also share patients with a chronic pain program at the Mayo Clinic. Mayo has a three-week, day treatment program for chronic pain, and sometimes we share patients that have significant problems with addiction. In some ways, chronic pain is like addiction in that it responds best to prolonged medical, psychosocial, and spiritual supports. The combination of treatments for those with pain and addiction should work very well, and hopefully new, non-addicting medications will be developed for chronic pain.

**Bill White:** Do you think the kind of integrated approaches that you're using right now at Hazelden Betty Ford may open up some new avenues and models for the treatment of concurrent addiction and chronic pain?

**Dr. Marvin Seppala:** I really hope so. I believe that is true. We are using a rich psychotherapeutic approach to both chronic pain and addiction that promotes healing and personal accountability. Some folks with chronic pain and opioid dependence actually respond well to lower dose Suboxone treatment. You're able to address both conditions with the same medication and the same psychosocial and spiritual supports. In medicine, we don't tend to talk about the limitations of our treatments for chronic pain. People need to know those limitations. It's that very personal vulnerability that Twelve-Step programs address that can help someone with chronic pain examine and manage their life in the context of this condition, establishing hope and distinct means with which to move their lives forward in recovery.

### **Recovery Management**

**Bill White:** One of the trends you noted within the field are efforts to shift or extend acute care models of intervention to what you described in terms of recovery management. Do you see the

integration of medications and psychosocial supports as an integral part of recovery management?

**Dr. Marvin Seppala:** I hope this is going to be the case. Currently, I don't think it's adequately being done. There's still such bias against the medications or against the use of psychosocial treatments—presented as either/or options. I'm reminded of depression, where a combination of psychotherapy and anti-depressant medication has been shown to outperform either treatment alone. And yet, as with attitudes in our field, people are told to do one or the other. I hope we will find a way to escape this dichotomy. I'm hoping we can explore models of effective integration of what for too long have been viewed as incompatible treatments.

### **The Future of Addiction Treatment**

**Bill White:** What would your predictions be about how addiction treatment will likely evolve in the coming decades?

**Dr. Marvin Seppala:** Well, this may be a pipe dream, but I hope we get medicines that can actually reduce or stop use of these substances while continuing to recognize the need for inner healing and the value of psychosocial and spiritual supports in long-term recovery. My colleagues who are primarily pharmacologists don't recognize this latter side of things and the need for them based on all the shame and guilt that addiction brings to the table. Abstinence is not enough. I hope we get genetic testing soon so that we have predictors of risk for our children and our youth. The use of this technology will be fraught with complex ethical issues, but it may open up whole new approaches to prevention and early intervention. I hope we continue to view addiction as a bio-psychosocial, spiritual illness. I think all four aspects of that description are necessary no matter how good our biologic treatments get. Addiction is a complex and unusual illness. It's too easy to become reductionistic by defining it from one perspective that can be treated with one approach. I hope we can become a more mature and unified field that utilizes everything available to us in the treatment of addiction. I am also excited about the new field of positive psychology. George Vaillant writes in "Spiritual Evolution" about how the positive emotions are a force for healing in 12 Step programs. I would like to see us harness the therapeutic healing aspects of love to improve addiction treatment outcomes.

**Bill White:** What are your thoughts about the past, present, and future role of psychiatry in the treatment of addictions?

**Dr. Marvin Seppala:** In the past, I would say that psychiatry was of little help in the treatment of addictions, except for certain practitioners that were able to see beyond traditional psychiatric models of care. Presently, I think psychiatry plays an important role, especially in the treatment of co-morbid medical and psychiatric illness, but unfortunately, those potential contributions have not been fully integrated in most addiction treatment settings. In the future, I hope such integration takes place. I think psychiatry can bring a great deal more than it has to the addiction field and improve our treatment outcomes. And I think there is much the addiction field has that can contribute positively to the field of psychiatry, such as a spiritual approach to chronic illness and consideration of healing via enhancing the positive emotions.

## Career Retrospective

**Bill White:** You know, as you look over your career to date, I'm wondering if you could identify some of the people who've exerted the most influence on your thinking and practices within the field?

**Dr. Marvin Seppala:** There have been so many people. I mentioned the lab at Mayo where I first got sober and fell in love with medical science under the influence of John Shepherd and David Donald and all the fellows that worked in their labs. During medical school and residency, I would give Dan Anderson a call at Hazelden, and he'd tell me to come on up and visit with him. It was amazing when I think about it, Bill, because I'd call him up and he'd say, "Aw, just come on up." And I'd go there and we'd just sit down and talk. He was a remarkable guy in so many ways and was such an influence on me. He always had time for me and introduced me to many people in this field. He had a real grasp of treatment for addiction and was so instrumental in making Hazelden what it is.

Ed Juergens was a counselor at Hazelden who was not my counselor when I was there in 1974, but was the other counselor on the unit I was on and later became a friend. Ed spoke about love and emphasized spirituality and in that way exerted a great influence in my life. Joe Westermeyer at the University of Minnesota was a wonderful teacher about addiction, as was George Valiant through the influence of his writings on alcoholism and positive psychology.

LeClair Bissell was involved in ASAM for years and at the time I joined, she was a tremendous voice for the patient and for the ethics of our field. She was a great influence. Also of note is Dr. Dick Heilman, a psychiatrist at the University of Minnesota, who also worked at the VA and did consulting at Hazelden and who had great passion for this field and the patients it served. I've known Ernie Kurtz for a long time and his books, especially *Not-God*, played a huge role for me in understanding the history of AA and its cultural influences. And there have been numerous addiction counselors over the years who shaped how I now understand and work with patients in treatment.

**Bill White:** When you look over this past quarter century working in the field, what do you feel best about?

**Dr. Marvin Seppala:** Direct patient care has meant so much to me over the years. I was at an Oregon Ducks football game last fall and a woman was sitting directly behind me who'd been in treatment where I was a psychiatrist. She tapped me on the shoulder, and we talked for a while. She shared that she's continued her sobriety and thanked me for the care I provided during that time. It doesn't get any better than that. I see those I have served all these years as "my people." That's what I like doing. Being able to work in addiction full-time and establish the value of the role of addiction psychiatry in the treatment of addiction has been very important to me. I think I've made a difference in the field, both in terms of an emphasis on treating addiction as a chronic illness and use of recovery management tools.

I didn't mention it earlier, but when I first was faced personally with whether I should pursue Suboxone and Vivitrol within Hazelden Betty Ford Foundation, I balked. I didn't want to be known as the guy who did that, but the truth is that this has been one of the most gratifying

things I've done in my professional career. This bridging of science and spirituality is one of the things I hope I will be known for within the field.

A final thing I feel good about is my teaching experience within the Hazelden Graduate School for Addiction Studies. There was a period in which I taught a course on an annual basis. I've given lectures at medical schools and the like and to other docs at conferences, but I would say that the most fun and most gratifying teaching experiences have been at our graduate school for addiction counselors.

**Bill White:** Dr. Seppala, let me ask one final question: is there any guidance you would offer a young physician or a counselor who was considering spending his or her life working within this field?

**Dr. Marvin Seppala:** I wholeheartedly support anyone who wants to work in what has been such an exciting, evolving field of service. There are so many questions we have yet to answer. If you are inquisitive at all, this is a great place to be. We're going to learn so much about the brain and addiction in the coming years, and people will have an opportunity to contribute to that new knowledge. And, of course, we get to deal with really remarkable people, patients who get well, many of whom go on to exceptional levels of achievement.

I keep thinking about the guy at Mayo who told me I was throwing away a good career in medicine by choosing to specialize in the treatment of addiction. I am so glad I made that decision. So many people see this as difficult work and think that no one ever gets better. It's hard to convey to people the joy one can find working within this field and what it means to witness so many people transforming their lives and the lives of their families through the recovery process. My suggestion for those feeling a call to work in this field is quite simply to pursue specialized training that will allow you to join those of us who have found this special service arena so personally and professionally meaningful.

**Bill White:** Dr. Seppala, thank you for taking this time to share your experience working within the addictions field.

**Dr. Marvin Seppala:** Thank you, Bill. It has been a pleasure being able to share my life and career with you.

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