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Cross-cultural Addiction Psychiatry: An Interview with Dr. Joseph Westermeyer

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Introduction

One of the pleasurable discoveries within my explorations of the literature of addiction psychiatry has been the work of Dr. Joseph Westermeyer. That discovery was made

many years ago while first researching the history of addiction recovery within American Indian communities. Dr. Westermeyer's studies were among the first to expose the "firewater myths" that had long pervaded the portrayal of alcohol problems among American Indians and were among the first to delve into cultural pathways of addiction recovery. His work exerted a profound influence on the book, *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery* (Coyhis & White, 2006). Since writing the book, I have become a student of his prolific body of contributions. In December 2013, I had the opportunity to interview Dr. Westermeyer

about his life and work. Please join us in this engaging conversation.

Early Career

Bill White: Dr. Westermeyer, you completed your early medical education in the early 1960s. How would you describe medical education about addiction during that time period?

Dr. Joseph Westermeyer: During the first two years of basic science education, it was pretty minimal. We did learn about the metabolism of alcohol and how alcohol fit into the metabolic cycles. We learned about the physical pathologies associated with alcohol dependence and with drug abuse. We learned a fair amount in terms of the basic physiology and pathology. We didn't learn much about the behavioral concomitants, the addiction sequences that occur. And there wasn't much yet known back then about the neurotransmitter roots of addiction. By the same token, in the third and fourth years of medical school, we were exposed to a tremendous number of clinical

experiences with people who were actively addicted to alcohol or other drugs. There was a marked discrepancy between the relatively focused and minimal information that we had during the first two years, probably adding up only to a few dozen hours, and the huge amounts of exposure we had to those conditions clinically, which would have amounted to hundreds of hours.

Bill White: Yeah. In the late 1960s, you returned to school to pursue degrees in specialty training in anthropology, public health and psychiatry. What spurred your interest in those areas?

Dr. Joseph Westermeyer: This interest grew out of my experiences in medical school, as well as in general practice. For example, my first patient when I was in medical school in my third year was an American Indian man who was a veteran of World War II of a notable battle in the Pacific (i.e., Tarawa). A schoolteacher, he was dying of cirrhosis of the liver. So, that event had an effect on me. While I was in general practice, I continued to see people with alcohol and drug problems.

My general practice in St. Paul exposed me to three major communities. One was a combined French-American and Native-American community whose members had ties to reservations. The second was a Scandinavian group, who, unlike many Scandinavians, weren't Lutherans. They were Baptists who had fled Scandinavia during pogroms against that group around 1900. The third community was Polish Catholic. The ways in which these different communities manifested their behavioral and family problems was of great interest to me and stimulated my taking anthropology courses on my afternoon off (a common custom during that time when medical practice involved being available 24/7).

Bill White: If I recall, you were also involved in Southeast Asia during that period. Is that correct?

Dr. Joseph Westermeyer: Yes, that was after three years in general practice. I had completed my course credits for a Masters in anthropology, and I was interested in having a total cross-cultural experience. I looked at a variety of options and ended up going with the U.S. Agency for International Development to Laos for two years as a primary care clinician. Part of my role involved public health programs and that got me interested in public health as a venue to improve people's health.

Addiction Specialization

Bill White: How did you move from that focus to the more specialized area of treating addiction?

Dr. Joseph Westermeyer: I entered a psychiatry residency at the conclusion of my two years in Laos. The program at the University of Minnesota fostered people working on a master's degree while they did their residency program, which might vary from three to four years on average. I returned to the University of Minnesota as a graduate student in anthropology and also matriculated as a graduate student in Public Health. I finished my Public Health training toward the end of my residency.

Bill White: You were part of a vanguard of physicians and psychiatrists involved in NIDA and NIAAA's Career Teacher Program. Could you describe that program from your perspective and its significance within the history of modern addiction medicine?

Dr. Joseph Westermeyer: For me personally, that came at an excellent time in my career. I had finished my residency program three years earlier and had been a Junior Staff Member in the Department of Psychiatry at the University of Minnesota. I had begun to do some research on my own, and had returned to Laos on three occasions by then. My career was just beginning to take root, and then the opportunity arose to join this consortium of people from around

the country who were brought together by the National Institutes of Health. It was a boon to me personally because I got to meet people who were interested in addiction at a time when there were very few people at my own institution who shared this interest. We met about four times a year for a week at a time and, in the first year, spent about three months at one or another facility that was involved with addiction care. Through the Career Teachers Program we came to know one another and had our interests in addiction treatment supported. It was a tremendous opportunity for many of us as individuals, but it also was a great advantage for the country and for medical education at large. This was the beginning of formalizing many guilds or professional organizations that took root among these early "career addiction fellows."

Bill White: It seems that the early roots of a professionalized field of addiction medicine date to this program and that period of time.

Dr. Joseph Westermeyer: Yes, the first formal organization that came out of that Career Teacher Program was a group called the Association for Medical Educators and Researchers on Substance Abuse (AMERSA). That group continues today. It's been in existence for over three decades. Two other groups influenced by the Career Teacher group was the American Association for Addiction Psychiatry, later rechristened the American Academy of Addiction Psychiatry and the American Medical Society for Alcoholism that later became the American Society for Addiction Medicine. From the beginning, the Career Teacher Program wasn't focused just on psychiatrists; it also had family practice people, internists, pediatricians, and psychologists, and basic scientists involved.

Teaching and Clinical Work

Bill White: Now, from the Career Teacher Program, you spent a considerable portion of your career as an educator and as an academic administrator. If you look back

over that aspect of your career, what do you feel best about?

Dr. Joseph Westermeyer: I have enjoyed my clinical work with patients who have addiction problems. I still spend most of my clinical time with such patients. At the same time, I enjoyed my mentoring medical students and psychiatrists, as well as anthropologists, psychologists, and epidemiologists during their training time. And I've enjoyed my research, which has intersected with both my clinical work and my educational work. I continue to enjoy my research activities. All of these have been major themes in my career. I've cut back on administration time. I continue to work as a clinician, a teacher and a researcher.

Bill White: In terms of the clinical work, I have the impression that the Veterans Administration has been a laboratory of learning over the course of your career.

Dr. Joseph Westermeyer: Yes, that's true. I came to be the Chief of Mental Health Services at the VA about twenty years ago this year. The opportunities at that time were tremendous. We had a program that treated about 200 addicted inpatients per year and perhaps another 200 addicted outpatients. Now, at least ten times that number of addicted patients are treated on an annual basis. The variety of disciplines and treatments provided to them are much more diverse. We are involved doing consultation with inpatients on the other services, as well as providing services to clinics located in rural areas through tele-services.

Cultural Psychiatry

Bill White: You became interested in cultural psychiatry at a time psychiatry was evolving from psychoanalysis and psychotherapy to biological psychiatry and psychopharmacology. How did you swim upstream against this trend and develop a focus on cultural psychiatry?

Dr. Joseph Westermeyer: Initially, I found people at the University of Minnesota as a graduate student and as a resident, and later when I was in general practice and in Laos, who were willing to help and support me along the way. Two were psychiatrists, the Chief of the Service and a psychopharmacology researcher (i.e., Drs. Donald Hastings and Bertrum Schiele), who eagerly supported my interests. And I'm not sure why, looking back on it. Neither of them had a background or even an interest in culture. One was an analyst and psychotherapist; the other was a psychopharmacologist. It may have been a time when academic psychiatrists were more willing to foster diverse explorations in the field, as compared to the more recent trend to help only those with one's own special interests.

I also found people in anthropology who were supportive. One was Dr. Perti Pelto, an anthropologist interested in research methodology and culture. He imbued me with the importance of methodology in doing cultural psychiatry. I was able to take the methods and the skills that I learned in both psychiatry and in anthropology and apply them to my studies of addiction and other disorders. A burgeoning interest in anthropology around that time was "applied anthropology"—not just looking at cultures as an academic pursuit, but applying cultural information and theory to social problems and to cultural change. Through those people I learned about a North American psychiatrist, Alexander Leighton, who conducted cross-cultural epidemiological studies. The works of psychiatrists Ornulv Odegaard in Norway and Minnesota before World War II and Tsung Y Lin in Taiwan during World War II likewise stimulated my interest.

Three or four years out of my residency, mostly through the American Psychiatric Association, I found that there were other people like myself—young psychiatrists who had been in the Peace Corps or who had worked in ghetto settings or who had been in the Indian Health Service or who had themselves grown up in other

societies around the world and immigrated to the United States. There were also those who grew up in minority neighborhoods, African-American, American Indians, Hispanic neighborhoods, or who had come to the United States as refugees, oftentimes during childhood. These people were writing and researching. We would submit our articles to the American Psychiatric Association for its annual meeting and we'd be put in the same symposium of a morning or an afternoon, so we came to know one another and to learn from one another. We started an organization, of which I was a founding member, called the Society for the Study of Psychiatry and Culture, which still exists.

Bill White: Did your focus on cultural psychiatry ever stand as an obstacle for you within the larger field of psychiatry?

Dr. Joseph Westermeyer: My first reaction is to say, "Absolutely not." And I think that's true on a local level where people knew me. I was the President of the Minnesota Psychiatric Association on a few different occasions and always got a lot of support. Never did anybody take my cultural interest as a thing against me. But on a national level, other psychiatrists have been suspicious not only of myself, but other psychiatrists with cultural interests. I think we have to find some way of coping with that. Many people in the Society for the Study of Psychiatry and Culture should be national leaders in psychiatry but they're not. There was a time when another cultural psychiatrist and I were put up for a national office in the American Psychiatric Association and a group of psychiatrists started a write-in ballot to make sure that neither of us was elected. I can't help but think that our identity as cultural psychiatrists was offensive to them. For another example, I was the newsletter editor for the Addiction Psychiatry group for many years, and on one occasion, I wrote an editorial on statecraft in addiction, taking into account my years of experience with the World Health Organization and having seen countries either get deeper into addiction or

dig themselves out of their severe addiction problems. In that newsletter article, I made observations about ways in which the United States had done both productive and unproductive things to address the problem. The Steering Committee saw that editorial as a political liability, and the following month, they asked me to step down. Cultural psychiatrists tend to take on issues that can make some of our peers in psychiatry uncomfortable.

Bill White: What are some of the important lessons you've drawn from your cross-cultural explorations that would be important for front-line addiction counselors?

Dr. Joseph Westermeyer: I recommend Perti Pelto's guideline to inundate yourself in the culture, particularly if it is an unfamiliar culture that you are entering. If it was your own culture, you have to inundate yourself in subgroups within that culture so that you weren't blinded by your own idiosyncratic experiences. It's virtually impossible for any one individual to be fully enculturated into any and all aspects of their own culture, particularly if that culture has any complexity to it. So, the first step is inundating yourself, spending a year or two in that culture and going into it with a fairly open mind. Then, the second step would be to choose some topic or question of interest that you are willing to devote yourself to and learning more about it in the context of the culture. Then, the third step in this scenario is to undertake research, using both qualitative and quantitative questions. The qualitative questions give you a skeleton and a foundation and the quantitative questions add flesh and muscle and nerves to whatever it is that you are studying.

Bill White: So you must enter work within these cultures as a student rather than as a teacher?

Dr. Joseph Westermeyer: Exactly!

Bill White: One area of great interest to me is the collection of papers you've done on the

history of alcohol problems among American Indians and particularly, the firewater myths that have pervaded that history. Could you recap some of those myths and what you've since learned about alcohol problems and their resolution in Indian communities?

Dr. Joseph Westermeyer: The lessons were from American Indian communities here in the United States, but also in communities beset with opium addiction in Asia. Those interests grew out of my clinical experience. When I first began these explorations, there was the prevalent concept in American Indian communities as well as in communities in Southeast Asia that alcohol use in the former and opium use in the latter were not significant problems. They were portrayed as a resource that could help people relax, give them time out, and help them with recreation. Alcohol or opium relieved boredom or pain, and any problems related to such use were considered minimal – those were the prevailing viewpoints at the time. This notion of denial, first of all, held that there wasn't a problem. Second, if you provided contrary information drawn from clinical experience or epidemiologic studies, this information would be minimized: "Yes, there is a problem, but it's a small one." These were the attitudes of the movers and the shakers of the society who were in a place to do something about it. Third, if you got them to turn the corner (by showing them epidemiological data) and say, "Yes, there is a pretty serious problem if ten percent of our people have this addiction," then they would say, "Well, but this isn't our problem; other people brought this poison to us," or "This is not what we were like before this thing happened and now we're changed. We didn't do this to ourselves, somebody else is to blame. Somebody else has to solve the problem." In sum, the early denial of a problem was followed by minimization, and then by projection of responsibility for the problem being somewhere else. Sometimes, a community leader might say, "Well, this is your problem as a clinician, but it isn't my problem as a community leader." Or a

teacher would say, "It's your problem as a doctor, not my problem as a teacher." So, there are these three elements of denial, minimization and projection that you have to recognize at a basic cultural level before you can do anything beyond what we can accomplish as clinicians.

Bill White: One of the firewater myths is that American Indians have a biological vulnerability that makes alcoholism almost inevitable. This is in sharp contrast to more recent analyses that place the roots of alcohol problems in Indian communities within historical or cultural influences. How have you reconciled these views?

Dr. Joseph Westermeyer: Biological vulnerabilities do exist across individuals. Studies among American Indians and other groups show individual differences in metabolism and in vulnerability. However, the individual differences within any one culture greatly exceed the rather small differences that occur from one culture to the next. I don't want to ignore biological influences, but to ascribe this complex behavior solely to biology is an oversight.

Cultural, social, psychological, and familial characteristics are the domineering factors at the root of these problems. Biological factors provide the instrumental means by which these conditions are made manifest. In societies with very low rates of addiction, those folks who lose contact with their cultural roots have rates of alcoholism as great, sometimes even greater, than people that have already high rates of alcoholism. Culture and society really have been neglected as being potent carriers of the etiologies of alcoholism. By the same token, addiction involves physical processes along with psycho-behavioral and socio-cultural processes. Genetic components likewise play a role, but sociocultural factors can facilitate addiction in those with minimal genetic predisposition, or prevent addiction in those with high genetic propensity to addiction. But we can say that about virtually all of the psychiatric disorders that we treat - depression, anxiety and other physico-

psychological conditions--vary tremendously from one society to the next because of the basic socio-cultural-familial characteristics that trip them off and make them manifest.

Bill White: Did your work in Indian communities and in Laos inform your later interest in addiction problems among immigrants and migrants?

Dr. Joseph Westermeyer: I've been interested in how some groups have been able to reduce their substance disorders with migration or immigration, while other groups have the problems continue or worsen. Following immigration, some ethnic groups have developed alcohol problems in just the way that alcoholism developed among many American Indian tribal groups. Opium-smoking developed among some but not all cultures in Southeast Asia following immigration to the United States.

Bill White: What do you think shifting policies toward cannabis will mean for the future of cannabis dependence and its treatment?

Dr. Joseph Westermeyer: If medical marijuana plays out like iatrogenic opioid addiction has, we can expect that cannabis addiction will increase over its recent 4% prevalence rate in adults (2011 data). However, we may not be aware of the nature and extent of medical marijuana problems for decades since – like Native American binge drinking and Asian opium smoking in the past -- the early stages will remain largely hidden. If our current cannabis epidemic expands, the problems will accrue incrementally over a few decades. Eventually, when virtually everybody is involved in some way or another with the resulting problems, the society can no longer ignore their import and the need to do something about them arises. This scenario has prevailed with our alcohol and iatrogenic opioid epidemic; it is reasonable to expect that it will play out similarly with cannabis.

Evolution of Addiction Treatment

Bill White: You've worked for more than four decades in that field of addiction treatment. What do you think are some of the most important historical milestones within addiction treatment over the course of your career?

Dr. Joseph Westermeyer: Perhaps, the most momentous thing I've seen take place is how national, state, and community leaders outside of clinical medicine have begun to pay attention to addiction. The involvement of community leaders, religious leaders, educational leaders, police departments, and the judiciary have created a social re-definition of the problem. Now we have drug courts. Instead of sending all criminal addicts away to prison, drug courts work with them to try and reverse their addiction. Many American Indian tribal leaders now will readily say addiction is one of their biggest problems. A few decades ago, the Native American leaders in Alaska, for example, decried a clinical investigator who called attention to the widespread alcohol abuse in Alaska. And now, I don't think you'd find a leader in Alaska who would deny that this is a major problem that he or she would have to address in their role as a community leader. Many religious leaders have picked this up. Educational disinterest is one weakness that remains, especially the college addiction problem. Many colleges around the United States have huge problems with alcohol abuse that unfortunately are not being resolved because educational leaders don't feel empowered or imbued with the notion that they can and need to do something about it. Or they minimize the problem by simply hiring a counselor to take care of this, but don't see it as something that all of their faculty, in all of their courses, and all of their students need to take to heart.

Bill White: You have witnessed the widespread dissemination of a whole new generation of medications in psychiatry and I'm wondering if you recall what it was like when there were early attempts to use those

medications in the treatment of addiction--from anti-psychotics to anti-depressants to benzos.

Dr. Joseph Westermeyer: One of the biggest problems early on was the use of the benzos to replace alcohol and opiates. We've not yet gotten away from that practice. Large numbers of people abuse and become addicted to benzodiazepines. Early on, psychiatrists rarely prescribed benzodiazepines but are now one of the main offenders in giving people open-ended prescriptions for benzodiazepines. I think that that was and continues to be a problem promulgated by some primary care physicians and psychiatrists nowadays.

Early on, many alcohol and drug abuse counselors recommended cannabis to patients. That was a huge problem for many years until, eventually, the profession of counseling recognized that this was not helping. Many counselors ended up having enough problems so that they stopped prescribing or recommending cannabis to their clients.

In terms of the anti-depressants and the anti-psychotics and the mood stabilizers, properly applied, I think these have been a great help to many people during recovery. A proportion of people who achieve sobriety still have episodic depression, panic attacks, and so forth. These medications have been helpful to them. And some of our addicted patients, particularly those using stimulants or the hallucinogens, have psychotic episodes. Some of these conditions resolve without medications, but some don't. The anti-psychotic meds have helped these folks get their life back again.

Bill White: How would you characterize the state of addiction treatment and the addiction treatment field in 2013?

Dr. Joseph Westermeyer: There have been some wonderful accomplishments. The epidemiologic data reveal that middle-aged, middle class American males have benefitted greatly. The death rate related to alcoholism has improved considerably in

that group of men. Self-help groups or mutual help groups like AA, the residential programs, the health insurance that's been available – all of these interventions have benefitted the middle class, middle-aged, largely Caucasian male.

By the same token, if you look at the rates among women, although they're much lower than they are among men, they haven't improved very much. Or if you look at the rates among young men in their teens and twenties, those rates haven't improved and they may have even gotten worse. Elements of our society that were creating the greatest number of problems, the middle-aged, middle class males, have benefited, but we haven't made much of a dent with the others. That isn't to say that they aren't getting more treatment nowadays, but it certainly isn't preventing them from continuing to suffer health problems.

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

Dr. Joseph Westermeyer: We've been trying to share this problem with more and more people and I think we've succeeded. The American Society for Addiction Medicine (ASAM) outnumbers the American Academy of Addiction Psychiatry (AAP) by about three times. By the same token, there's plenty left for psychiatrists to do. We must avoid treating people with addictive medications that can expand their miseries rather than ameliorate them. Many people with addictive disorders who didn't have psychiatric problems prior to addiction do have psychiatric problems after addiction. It may be due to the drug itself, particularly the stimulants; cocaine and stimulant drugs that can precipitate psychosis or cause small strokes. Those folks can be changed irreversibly by their drug abuse. Traumatic brain injury is common in those with addictions. There's going to be ongoing need for us to be of help to addicted people with a wide variety of problems.

Bill White: Through your work, you've emphasized the role of community and culture in addiction recovery but you've also examined the role of medications in recovery initiation and maintenance. How do you see the future integration of medication with those broader psycho-social and community supports?

Dr. Joseph Westermeyer: I see it gradually changing over time. Initially, when I got into this field, we would be treating a patient with one of these medications and then refer them to a mutual help group, only to have the mutual help group start working on them to discontinue the medication. So that has been a problem, but sometimes it's been a help. I have a patient right now who has an unlimited supply of prescribed benzodiazepines and the group has been leaning on him to stop using benzodiazepines. Their intent for people not to abuse their medication has been wonderful. In addition, their leaning on people who are benefitting from the medication has definitely cut back from what it once was.

Some dilemmas do exist with certain medications. For example, Antabuse (disulfiram) can be a great help if it's monitored. If you just give the patient a prescription for three months and ask them to come back: I wouldn't even bother doing that. By the same token, we have a lot of patients who are on monitored Antabuse (e.g., their continued involvement at a job or the family providing shelter for them hinges on their taking Antabuse): that's been greatly effective. The use of contingency contracting with some of these medications has great potential.

Bill White: What do you see as the future of medications such as methadone and buprenorphine?

Dr. Joseph Westermeyer: I've been involved with methadone programs for over three decades, going on four, and I do have a certificate to prescribe suboxone. I have patients on suboxone, and I'm a Medical

Director of a methadone program. I'm in favor of these medications, but I'm not in favor of the way that these medications have been leaking out into the illicit supply route. Casual attitudes among some programs and some physicians about what happens to the medication and an over-expectation that the medication alone will provide a stable lifestyle are problems. Governmental agencies should be monitoring diversion. The overwhelming ease with which physicians, dentists, licensed nurse practitioners, and pharmacists, were willing to foster people being on huge amounts of opiates, or diverting opiates for profit into the illicit channel, fueled the iatrogenic opioid epidemic. A lot of work needs to be done to put suboxone and methadone back in their proper place. If that isn't done, society will take it away from the patients who benefit from it, as well as taking it away from clinicians like myself who feel that it's a very useful aspect of our armamentarium to help addicted people.

Career-to-date Reflections

Bill White: You have been such a prolific writer throughout your career. How have you been able to integrate that into your administrative, teaching, clinical and research activities?

Dr. Joseph Westermeyer: From childhood, I never got involved in watching TV. That void freed up most of my evenings for reading and writing. That habit was confirmed during my two years in Laos (1965-67), where there was no TV and evenings were given to reading, writing and studying Lao or Hmong languages. I like music, and often have music in the background when I'm reading or writing.

Upon returning to the U.S., I started residency. My days were given to clinical work, supervision, and frequent seminars, with evenings devoted to reading and writing. My wife started grad school, so her evenings continued along the same lines. And our children went to schools where homework was required. We'd take a study

break each evening to play Ping-Pong, darts, or make popcorn. So it became a family tradition. I'd also write on Saturday mornings if I didn't have hospital rounds, Saturday afternoon for chores, and Saturday evening for a party or dinner out. Sunday was for time-out with the family (church in the morning, skiing, swimming, etc. later in the day), but often reading or writing in the evening. On vacations, reading or writing in the evening was relaxing and enjoyable for me -- and still is.

Bill White: What have you liked most about working in this field now for these past four decades?

Dr. Joseph Westermeyer: Wow, that's a big question. I would say one of the things I've enjoyed is the opportunity to be involved in a societal issue much bigger than myself. I didn't think this through when I was a young man but, looking back on my own life and the life of my patients and my peers, I see a larger picture. Deciding early on goals that are bigger than one's self and that serve a larger social body is conducive to good mental health and getting through the vicissitudes of life. It's good to not just live for successes alone but to realize that you've identified yourself with an important social need.

Certainly, the improvement that I've seen in many of my patients has been a great support through my life. Even the reversals goad me on to keep involved. On a very personal level, my teaching and mentoring, as well as my research have provided many rewards in my lifetime.

Bill White: Is there any guidance you would offer a young physician or counselor who was just starting out and considering working in this field?

Dr. Joseph Westermeyer: First of all, having a real interest at heart would help. I mean, when I first began, there hadn't been any substance abuse in my family or in my personal life so I didn't have any personal motivations. By the same token, I had been

exposed to friends and relatives of friends who had this problem. I saw how devastating it could be. That level of knowledge helped motivate me to a considerable extent.

I also learned, both from my years in family practice as well as from my work in Asia that trying to reduce all human suffering to molecules, biological realms, or medications, was a false road. I began to appreciate how important family, neighborhood, society, and culture were in fostering health and dealing with major health crises. And addiction provided a model disease to pursue my broader interest in family, society, and cultural dimensions for all health problems.

Bill White: What do you hope will be the most important legacy you leave the field?

Dr. Joseph Westermeyer: Probably the biggest thing would be the people that I've mentored over time and the future contributions that they will make. I already see a number of them launching ahead in ways that overwhelm me with their insights and their motivations.

To a lesser extent, I hope some of the research that I've done has helped us move forward, like bricks in a wall. There is a wall of progress that requires many people to build. This approach is more evolutionary than revolutionary. They aren't the kind of thing that an Einstein provided in the way of a leap. But, I certainly feel good about having added bricks to the wall. In time, some of those bricks get worn out and are replaced by newer people adding their newer bricks and that's just fine. I have no difficulty with that.

And I think the lives of many of the patients that I've touched are a form of legacy. I don't think I could have accomplished what many have accomplished in overcoming their addictions and rebuilding their lives. That gives me strength even when I'm facing challenges that try me. It gives me faith in the human condition that whatever challenge I am faced with can change with time.

Bill White: Dr. Westermeyer, thank you for this interview and thank you for all you've done for the field and the people we serve.

Dr. Joseph Westermeyer: Thanks so much for inviting me to share these reflections.

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