White, W. (2008). Why addiction medicine? John P. McGovern, MD Award acceptance speech, American Society of Addiction Medicine, Miami, Fl, April 28. *Journal of Addictive Diseases, 27*(3), 3-5.

Why Addiction Medicine?[1]

Medicine's cultural ownership of severe alcohol and other drug (AOD) problems has been historically granted on only a probationary status. That ownership was revoked in the opening of the 20th century amidst a weakening of the field's infrastructure and public pessimism about the prospects of long-term addiction recovery. When America's first network of inebriate homes and asylums and private addiction cure institutes collapsed, a new generation of recovery advocates and addiction medicine pioneers rose from the ashes of that collapse. These individuals spent their entire lives changing cultural attitudes and forging new social policies that birthed modern addiction treatment. We owe a great debt to the vision, courage and tenaciousness of these men and women. The resurrected system of addiction treatment is again facing internal and external threats to its character and its future.

In the face of such threats, it is important to periodically ask why this country needs a specialized field of addiction medicine and a specialized arena of addiction treatment. My greatest fear is that the larger field of addiction treatment will disappear amidst the illusion of its continued presence. This could occur if we were colonized by more powerful forces in our operating environment in ways that corrupted our core values and service technologies. Given this threat, it is important to define for ourselves, for our communities and for the individuals and families we serve precisely what dimensions of addiction medicine and addiction treatment are distinct from all other health and social service interventions. Each of us would bring different perspectives to this question. For me, that distinctive essence rests in nine kinetic ideas from which the central actions of the field flow and that form a thread of historical continuity through which the field was birthed and has evolved.

<u>Proposition One: Substance use disorders spring from multiple etiological roots and vary in their severity, complexity, duration and outcome.</u> It is such variability that calls for advanced and specialized training, skilled differential diagnosis and highly individualized approaches to service planning and delivery. A specialized field of addiction treatment

[1] . Excerpted from the John P. McGovern, MD Award Lecture, American Society of Addiction Medicine, Miami, Fl, April 28, 2007.

would not exist but for the failure of other disciplines to adequately understand and effectively treat severe and prolonged substance use disorders.

Proposition Two: Addiction is a primary disorder and primarily a disorder of the brain. The addictions treatment field rests on the belief that, even when spawned by other conditions, substance use disorders achieve a level of independence that requires direct and specialized treatment. Addiction has long been characterized as a disease of the will, and recent scientific breakthroughs within our field confirm the biological roots of this incapacity to just say no. The essence of addiction treatment is not the temporary reversal of the physical, psychological or social consequences of addiction. It is found instead in the sustained amelioration of the rabid appetite that is the source of such destruction. A central rationale for our field's existence is that addiction recovery is best facilitated by practitioners who can distinguish addiction disease from the biopsychosocial consequences of alcohol and other drug use and who can offer their patients tools through which they can reclaim their health and their powers of personal decision-making.

Proposition Three: Well-intentioned but uninformed attempts to treat substance use disorders can result, and have resulted, in significant harm to individuals and families (1). The history of such iatrogenic insults spans coerced and prolonged institutionalization, mandatory sterilization procedures, invasive psychosurgeries, convulsive therapies, and drug insults that are incomprehensible by today's standards. The latter include lethal bromide therapies used for narcotic withdrawal, methamphetamine injections prescribed as a treatment for heroin addiction, and prescriptions of amphetamines and barbiturates as a treatment for alcoholism. One of the most fascinating accounts from my historical research is an 1889 medical journal report on the cure of a female morphine addict using two and one half pounds of prescribed cocaine. The journal account reported that the patient was "much encouraged" and "had ordered two pounds" more. The cure was confirmed by the account that the last time the physician saw the patient she assured him that she no longer had any desire whatsoever for morphine (2). It is easy to look at such treatments through the retrospective lens of history and self-righteously proclaim, "What were they thinking?" But history teaches that it is very difficult to recognize such insults in one's own era. This bodes humility and caution and the need for specialized training for those charged with treating addiction.

Proposition Four: Addiction recovery is a reality in the lives of millions of individuals and families. Addiction medicine is founded on a

deep belief in this reality, the importance of vividly conveying hope for full recovery to individuals and families, and the willingness to offer sustained guidance through that process. Other fields of medicine and social services witness the devastation of addiction. Addiction medicine is unique in its practitioner's ability to witness close up the transformative power of long-term recovery. A close connection to the recovery experience is the source of the hope that permeates our best service milieus.

Proposition Five: There are multiple pathways and styles of long-term recovery. These pathways encompass religious, spiritual and secular frameworks of recovery that vary widely across cultural context (3). All are cause for celebration. These pathways are reflected in the growing diversity of addiction treatments and peer-based recovery support structures in the United States. What we offer at our best are practitioners who possess a deep knowledge of and a deep respect for these diverse pathways and styles of recovery.

Proposition Six: Addiction recovery is more than the removal of alcohol and drugs from an otherwise unchanged life. The achievement of global health, or wellness, as an outcome of recovery is best achieved within a framework of treatment that focuses on the whole person/family (4). Facilitating the attainment of global health within the recovery process requires knowledge of the far-reaching influences of addiction, the stages of recovery, and the zones of action and experience within which recovery unfolds. That core knowledge and those core skills exist in no other professional field.

Proposition Seven: Recovery maintenance is a distinctly different process than recovery initiation. Brief biopsychosocial stabilization should not be mistaken for stable recovery maintenance. Such respites are as likely to mark milestones in a long addiction career as they are the beginning of a recovery career. We are perhaps the only profession that doesn't take pride in how good an addicted person can look after a month of supervised sobriety. The understanding of recovery as an enduring process underscores the importance of sustained monitoring and support, stage-appropriate recovery education and, when needed, early re-intervention—all provided by practitioners with an intimate knowledge of the long-term recovery process.

Proposition Eight: Addiction recovery is not durable until it is nested in the community—within the physical and cultural environment of each patient/family. Many patients with severe substance use disorders are deeply enmeshed in cultures of addiction that have come to dominate their lives. Recovery is an intrapersonal journey, but it can also be a journey from a culture of addiction to culture of recovery. The latter is reflected in the

proliferation of Twelve Step groups and adjuncts and alternatives to such groups. The potential role of peer support groups in the recovery process suggests the need for specialists familiar with the organizational structures, core concepts, catalytic metaphors, meeting rituals and cultural etiquette of these groups. It suggests the need for professionals who are skilled at matching and linking patients and families to these resources. Addiction specialists are distinguished by their knowledge of addiction, but even more so by their knowledge of the physical and social ecology of recovery.

Proposition Nine: Addiction medicine is founded on an empowering relationship that is free of contempt and moral censure, that is characterized by emotional authenticity and candor, and that is focused on the strengths and resiliencies of each individual and family. In contrast, those with severe alcohol and other drug problems have historically been greeted by other social institutions and professional helpers with moral judgment, contempt, service exclusion or extrusion and power struggles that often ended in maltreatment. The addictions field is also unique for its "wounded healer" tradition. More than any allied field of health and human services, we have a deep respect for the value of experiential knowledge. That knowledge transcends the issue of one's personal recovery status. We have long contended that the personality and life experiences of each practitioner constitute potent ingredients of therapeutic alliance and therapeutic outcomes. That degree of emphasis on use of self in the healing of others has few precedents in the history of medicine.

These nine propositions—perhaps most notable for their simplicity--and the distinct clinical practices that flow from them distinguish addiction medicine and the larger arena of addiction treatment from all other helping institutions and professions. Amidst the wave of service integration initiatives, it is important that these core ideas and service technologies not be lost.

We are in a unique position in this most unusual of occupations. We have the ability to both treat soul-corrupting illness and to witness individuals and families redefine themselves at a most fundamental level. In our best moments, we get to witness people rise from a state of utter despair to develop a quality of life and a level of citizenship and service that is sometimes spellbinding. There is nothing more sacred in this profession than the privilege of being part of such transformations. When we strip away all the organizational, professional, financial and regulatory structures, it is this unique human encounter and what we bring to it that distinguishes our field.

If the field should ever lose its way, if it should ever be abandoned to those who view alcoholics and addicts only as a crop to be harvested for financial profit, it is this power to touch and transform lives and these distinct ideas and service practices that will need to be rediscovered in the future. We each have a responsibility and role in protecting that legacy.

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