

# **The First Session with Substance Abusers**

## **A Step-by-Step Guide**

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### **Chapter 1: Who Is the Substance Abuser?**

When asked who is the substance abuser, most people, including mental health professionals, readily conjure up stereotypical images:

- The raucous middle-aged man with a big belly, bulbous nose, and pasty skin, reeking of alcohol
- The furtive young grunge who is rushing the compact disc player he has just stolen to the nearest "shooting gallery" to exchange it for a fix
- The streetwalker supporting her habit through prostitution
- The inner-city youth who spends most of his time in a "crack house," wherever it might be this week, or "dealing" to the often well-dressed occupants of the cars that pull up to the curb where he stands every evening
- The violent felon, twice imprisoned for assault, whose crime-ridden life is liberally laced with all kinds of drugs, as well as alcohol

The hard-core addict is easy to spot. Harder to spot but nevertheless more common is the substance abuser who is a next-door neighbor, a coworker, or even a colleague. Consider the case of Florence, who I (Nick) saw just two years ago.

Florence had a Ph.D. in social psychology and was a full professor at a prestigious university. She also was the principal investigator and project director of a brilliantly conceived and executed program for inner-city adolescent girls. She spent every Saturday morning on-site with her abused adolescents.

Recently, on the way to the center, which was in the heart of the inner city, she was severely beaten and robbed. Once out of the hospital, where she was treated for severe wounds and three broken bones, her doctors referred her for treatment of posttraumatic stress disorder (PTSD). She chose to see me, even though it meant traveling a considerable distance every week for her sessions.

It was obvious that she was a brilliant and compassionate psychologist, well deserving of the reputation she had in the field. I was initially quite taken with the way she spoke of her involvement in the amelioration of the severe abuse to which inner-city girls were subjected. And at first I admired how quickly she had returned to her Saturday work in the inner city. Her doing so was against all medical advice, as her injuries were not yet sufficiently healed.

Then I noted certain inconsistencies that jolted me out of my Mother Teresa countertransference. Her ready return to the inner city was not in keeping with her diagnosis of PTSD. She looked twenty years older than her age of fifty-four. Her skin had a distinct alcoholic pallor along with premature wrinkles. Her hands revealed a tremor in spite of her attempts to hide it by clasping them. Was Florence a substance

abuser who already manifested organic signs?

Through a series of interviewing techniques based on the approach that we will discuss in later chapters, I learned that Florence used her weekly trips to the inner city as the opportunity to buy her week's supply of drugs. She lived alone, and every night she smoked crack. Then she would go to bed with a bottle of wine, a behavior known among addicts as sucking on a lemon. Having finished the wine, she would eventually fall asleep. But a stupor is not restful sleep, and the next morning Florence would "crank" herself with uppers (amphetamines) she had also purchased from her corner pusher.

I pointed out that for someone who was trying to improve the lot of people in the inner city, she was participating in one of its most unfortunate aspects. In full denial, Florence reminded me that she was an excellent social psychologist and understood too much about the problems to ever get addicted.

Florence heaped rationalizations upon each other with the intensity of one who must avoid facing the truth. I responded that I had read the story. It was called *Rain*, and it was written by W. Somerset Maugham. It was about a missionary who set about to save the soul of Sadie Thompson, a prostitute. Instead, he found himself partaking of the "sexual depravity" he had been condemning, and he took his own life. I asked if, indeed, she was not taking her own life little by little, the hard way.

Florence determined at that session to enter treatment and go clean. But it was not to be. Three days after our appointment, she was readmitted to the hospital, this time with advanced cirrhosis and pancreatitis, as well as other conditions, all related to her prolonged substance abuse. She died before I could see her again.

We purposely chose to present the case of Florence to demonstrate that the substance abuser not only may be anyone but also may be a person we like, respect, and admire. She may even be one of us.

### **ERRORS IN POINTS OF VIEW**

Before looking extensively at the unlikely array of patients you will certainly see and, we hope, appropriately identify, it is important to see how the inherent biases of those people most involved result in their missing or purposely overlooking the chemical dependency surrounding us. Because of the issues hidden in these points of view, therapists are often thrown off the track and are thus prevented from providing useful help.

#### **The Cultural Point of View: It's All Relative**

In addition to differences among families in tolerance or acceptance of substance abuse, there are cultural differences in what is deemed OK. In the inner city, drugs are easier to obtain than bottled water, and children play while their single teenage mothers smoke crack. Children as young as eight are recruited as runners, and gang membership is a matter of survival. But our African American and Hispanic colleagues who work side-by-side with us treating substance abuse have made it very clear that factors stemming from poverty, resignation, or despair do not properly define a culture. They remind us that cultural tolerance in no way lessens the ravages of substance abuse on children and adults. We have relied on these colleagues to help us sift acceptable from unacceptable behavior in the light of cultural variables. But they have hammered into us over and over that when we are confronted by the denial of an addict, our need to confront that denial is necessarily ubiquitous—it knows no cultural boundaries. A therapist who holds the point of view that drug addiction differs according to culture or skin color can dilute and hamper the work he has to do.

True, there are cultural differences as to the definition of social use, but the patients who come to us have already slipped far down the slope of addiction, or they would not be seeing us. You must be cognizant that an addict will attempt to excuse his addiction by proffering the claim that his behavior is considered socially acceptable by his ethnic or cultural group. Our job is to treat addicts, not to engage in philosophical discussion of what is culturally or ethnically acceptable social behavior.

These considerations are integral to establishing a therapeutic alliance with the chemically dependent patient, and we will be discussing them in detail. In addition to the biases developed from our families and culture, there are other points of view that obscure what is happening in the first session.

### **The Patient's Point of View: It Ain't Me**

To the patient, the addict is always the other guy. It is very interesting that when patients identify the other guy, they can be amazingly accurate. This is because those who are chemically dependent read a great deal on the subject (some are even reading this book) and understand it as only one who has been there can; but then they do two things, both of which they do well: (1) they project their knowledge onto those around them who are abusers, and (2) they bolster their own denial by comparing themselves to those exhibiting levels of addiction more advanced than their own. They thus succeed in avoiding even a modicum of self-understanding.

Friends, including behavioral health practitioners, are often startled when someone ostensibly close to them enters a drug rehabilitation program after years of chemical dependency unnoticed by anyone. They are even more startled when one or two in their circle enumerate accurately the telltale signs that had been present for months or years. Persons who had noticed may be skilled practitioners who understand addiction, or they are recovering addicts, but more often they are persons who are living in denial of their own addictive problem.

After Florence died, a member of her psychology faculty was outspoken in deriding his colleagues for having overlooked the signs that Florence had been exhibiting. Actually, Florence had kept her chemical abuse successfully hidden; nonetheless, he loudly proclaimed that had her colleagues been more vigilant, she might still be alive. Not quite a year later he was admitted to a drug rehab program for his own abuse of many years' standing. In having concentrated for years on Florence's subtle symptoms he had avoided looking at himself, and in deriding the faculty he may have been uttering his own unconscious plea for help.

When a substance abuser gets into trouble, she can always find another addict who is in even greater trouble, implying that it is the other person who is the addict, not she. If arrested for driving under the influence (DUI), there is the excuse, "I am not like the other people appearing before the court today who are here for the second or third DUI." When the second or third DUI arrest occurs, the excuse is, "I'm not the drunk who caused an accident or ran over a pedestrian." So pervasive is denial that every arresting officer jokes that all drunk driving can be explained by the universal lament, "Honest, officer, I only had two beers." (The person's blood alcohol level tells the true level of alcohol consumption, contradicting the legendary two beers.) Similarly, the person fired for being drunk or stoned on the job or for frequent absenteeism rationalizes, "At least I got another job right away, so I don't have a problem like the unemployed guy. I just had a boss who had it in for me." The "boss who had it in for me" excuse is good for a succession of job losses, up to and including the final one, after which the drunk or stoner is too far gone to get another job. Thereafter, he repeats over and over to anyone who will listen (usually his own inebriated friends) the story of the unfairness of that

terrible last boss. Even now he is denying the problem!

In explaining how facile this denial can be, we can use the analogy of a person whose calorie craving has resulted in his being overweight, a very common phenomenon in American society. The woman who is obese will make certain there are no full-length mirrors in the house. By seeing only the reflection of her face, she can pretend she is only a little overweight. If when going by a large plate-glass window she inadvertently catches the reflection of her full body, she will experience initial shock at seeing her true girth. Then denial will resume, and she will remind herself that plate glass always distorts. A fat man sitting in a room when another obese man walks in will smirk to himself, "My belly isn't as big as that guy's." Actually, his is probably a lot bigger, and that is why he desperately needs the denial.

### **The Family's Point of View: Blame the Addict for All Trouble**

Because a spouse or other family members are clamoring for treatment of the chemically dependent relative does not mean that they want the effective or appropriate treatment for that person. There are many exceptions, of course, but practitioners are amazed how often a family that is demanding treatment turns around and sabotages it when arrangements are made. A family member—especially the spouse, lover, or parent—is more often than not the patient's enabler, defined as the person who makes possible the continuation of the offender's addictive behavior. It is not uncommon for more than one member of the family, or even the entire family as a unit, to behave as enabler. Examples of enabling behavior abound.

An alcoholic in our program had been dry for six weeks when his spouse, who never drank, joined the Wine of the Month Club and received a case of fine wine early each month. She would open each case and array the bottles on a counter in the laundry room. By the third month, the patient, who had then been dry for over four months, unable to resist any longer, opened the first bottle and was within one day back to his previous binging behavior. The wife was furious; she complained to the therapist that treatment was not working and informed him she had no intention of paying the overdue bill for his services.

We were consulted by the juvenile court when a frequent school problem got out of control. A group of high school students were caught smoking pot a block from the school during the noon recess. They were suspended from school, and the matter was remanded to the juvenile authorities, as the inhabitants of the apartment building where this took place had called the police.

Along with their lawyers, the parents stormed the school and the officers, charging the authorities with everything from false arrest to brutality (one girl had tried to scratch the arresting officer's eyes and had to be restrained).

Schools and police know this scenario well in all of its variations, and they refer to it as the "everyone else but not my darling" syndrome. No wonder that Carroll O'Connor, the actor who lost a son to heroin, admonishes unequivocally, "Get between your child and drugs any way you can." There are certainly parents who do this, but the enabling parent is all too common today. Those parents who really want to respond appropriately may find it difficult in the current "blame the schools" climate. Psychotherapists need to be cognizant of the parents' plight and be prepared to assist sincere parents, especially when their tough love may be required.

There are principally two reasons for enabling behavior. The first is that the enabler has issues that require the continuation of the substance abuse on the part of the spouse,

lover, parent, or child. These issues may range from a need for a feeling of safety-"he won't be able to leave me"-to a need to be in charge, which the addict's debility accords. When the situation gets out of control, the enabler seeks help for the addict but aborts that help just as soon as the status quo has been restored. The "Wine of the Month" case is such an example. The wife insisted her husband seek treatment when the alcoholic behavior resulted in his losing his job. After he had been sober long enough to obtain a new job, she sabotaged the treatment.

The need to maintain a family mythology is the second reason for enabling. Although the foregoing case of the outraged parents would fit into that definition, the family mythology is usually more pervasive, as the case of Megan illustrates.

Megan, a beautiful, classic blonde in her late twenties, was the second wife of a handsome, successful, and debonair middle-aged man, Bob. There were two young children as beautiful as their parents, and the home was perfect and worthy of being featured in *House Beautiful*. Bob liked cocaine and had the income to indulge in it frequently. On occasion, and especially on weekends, he would mix cocaine (an upper) with alcohol (a downer), a form of "speedballing" that would result in abusive behavior; sometimes he would beat the children, but mostly he would batter his spouse.

Megan had a need to present an idyllic picture to her parents and to the world, and indeed, "perfect" was the word used by friends and others to describe this family. Megan created a family mythology to sustain the illusion. The children were indoctrinated with the excuse that Daddy worked hard and could not help "blowing off steam," and they were never, never to mention to anyone that Daddy hit them or their mother.

On one occasion, when Bob had battered her to the extent that make-up would not cover the bruises, Megan crashed the car into an abutment so that she could attribute the bruises to the automobile accident. The children dutifully maintained the family mythology, even after Bob overdosed and had to be hospitalized. Megan whisked him off to an expensive private rehab program in a distant city so that all could be hushed up.

Megan was an enabler, and she taught her children to be enablers. It was only after Bob died of an overdose that Megan was finally distraught enough to tell her therapist the truth. She had to grapple with the guilt that, perhaps, without her enabling behavior Bob might have had to get help before he eventually died of his abuse.

Whether family members are sincere or are enablers, they need to be involved in the substance abuser's treatment. We are often asked how one can tell the sincere family member from the enabler. This is difficult, because all family members are sincerely in denial, even the ones who are not the primary enablers. The primary enabler needs treatment to understand and change that behavior, and family members who are not enablers need help in addressing the guilt feelings stemming from their mistaken belief that they are causing the addictive behavior. The latter issue is very common for children of all ages (even after adulthood) who have been taught by an enabling parent to take responsibility for mom or dad's chemical dependency.

It is important that the enabler not be misdiagnosed as sincere, and vice versa, a differentiation that you cannot easily render without meticulous clinical consideration. A rule of thumb is to regard the family member or members who are making the most noise and avidly blaming the addict for everything as the most likely to emerge as primary enablers. The nonenablers are more circumspect and are likely to be as weary of the enablers as they are of the addict. The nonenablers do not need the addict in order to validate themselves, whereas this is the presenting issue with the noisy, complaining

enablers. The enablers clamor, "I would be happier and more successful and would have no troubles," without the addict. These same enabling family members will be the first to "rescue" the addict from the therapy by sabotaging the treatment just as it begins to produce results. Without family involvement, few addicts succeed in treatment. So important is this consideration that we have devoted all of Chapter Eight to the enabler.

Probably the most frequently encountered family problem is that of spouses who have finally left their addict and have decided to rebuild their lives without him. There is a tendency to respond to the patient's plea and return to the marriage after too short a period of sobriety. The enabler will do so out of need to return to the halcyon days of a false but safe relationship; the sincere spouse will feel guilty that not to do so would jeopardize the spouse's recovery. Without counseling, both types of spouses will invariably make the wrong decision.

The second most frequently encountered family problem involves the exasperated parent or parents who have finally thrown out the adult child who is abusing drugs. The temptation to let the son or daughter prematurely return to the home with the first sign of recovery is intense. Probably these parents have been enablers all along, but in any case, the parents must be counseled that an important part of any person's recovery is for her to become self-supporting.

### **The Medical Point of View**

To satisfy the medical definition of addiction there must be "physical cravings" on withdrawal, as manifested by an array of physical symptoms; withdrawal from opioids (for example, opium, its derivatives, and its synthetic variations: morphine, dilaudid, percodan, heroin, and so on) has always served as the model. This definition has proven not only inadequate but also unfortunate, in that it does not explain the severity of many addictions. It has led the medical profession and the public to believe that any substance that has not been declared medically addictive is not a matter of concern. As noted previously, the assurances by both the government and the medical profession lulled many into believing cocaine was not an addictive substance. History and clinical experience have demonstrated that faulty assurances coming from ostensible authorities served as an inadvertent and tragic impetus to the cocaine epidemic.

Historically, it would seem that under the medical definition, every substance is presumed nonaddictive until proven otherwise. Innocent until proven guilty is important in criminal justice; it is nonsensical in the physical world. This is not mere rhetoric, for every new sedative, pain reliever, or mind-altering drug that has become part of our pharmacopoeia was initially heralded as being nonaddictive and without side effects. In the absence of any evidence, it may be impossible to predict that something will be addictive, but there is also an overriding responsibility not to prematurely declare that something is nonaddictive. Time reveals the fallacy of such declarations as one by one, everything from benzodiazepines (for example, Valium) to methadone shows up on the street for sale to addicts who clamor for them. Even Ritalin, a stimulant prescribed and perhaps overprescribed for attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD), has a street value, and it is often peddled to middle schoolers by the very children for whom it is prescribed. These boys often manage to build up a stash that allows them to sell the surplus for as much as two and three dollars a tablet. Only time is necessary to reveal the consequences of continuing to assure the public that each new mind-altering drug is not addictive.

Of importance to you in the first session is to be mindful that a prescription drug, dispensed legally and responsibly, may have become an addictive substance with prolonged use. Too many therapists erroneously believe that prescription drugs are safe,

when in fact there are far more people in the United States addicted to medically prescribed "safe" drugs than there are addicted to heroin, cocaine, and other illegal drugs combined.<sup>1</sup> Be wary of the patient who complains that only a certain drug is helpful; she may be addicted to that drug.

We have prepared Chapter Three to alert you in the first session to the kind of person most likely to become addicted to particular drugs. In addition, we have grouped drugs according to class; we do this because once a person is addicted to a drug, he is addicted to all drugs in that class. The medical profession is too often oblivious to this transfer to an addictive equivalent; physicians often use drugs of the same class as substitutes for another drug to which the patient was obviously addicted.

### **The Psychological Point of View**

The psychological point of view that regards all addictions as being learned behaviors would seem to stand in direct contradiction to the medical point of view that insists in all cases that there be a physiological basis. To the behaviorist there are no "addictions" in the strict sense, as the behaviors so labeled are really habituations that can be unlearned. Treatment, therefore, is reconditioning, deconditioning, negative response extinction, or whatever term might be applicable to explain the unlearning.

Under discussion here are not the excellent behavioral techniques being used in rehab programs that respect the physiological aspects of substance abuse, but rather those approaches that deny cellular changes in addiction and offer the patient the hope of becoming a "controlled" drinker. This term seems in itself to be an oxymoron, for the only persons who count drinks and are obsessed with controlling their ingestion of alcohol are the alcoholics, who invariably lose count and, therefore, control.

Most of us were trained in the context of the psychological definition of addiction, and as such are prey even before the first session to the patient's insistence and belief that she can, with a little help from us, succeed in restoring chemical equilibrium. Throughout this book we caution you against espousing a purely psychological model of substance abuse. It is as seductive to the psychologist as the solely medical model is to the physician.

It is the ubiquitous fantasy of substance abusers that they can become "social" users, and they really do not need a misleading psychological theory to bolster their denial of the importance of abstinence. We recall a patient who had been through three unsuccessful controlled drinking programs before entering our program. He was doing well, and he had been abstinent for over seven weeks. Then he missed the evening group in the eighth week. He telephoned two days later, stating he had been practicing his controlled drinking when somehow he seemed to have forgotten a lesson or two and found himself "unexpectedly drunk" for several days.

### **A PRAGMATIC POINT OF VIEW**

Both the medical and psychological models are important in the treatment of substance abuse, but only in combination with each other, not singly. In this section we look at such a combined model, pragmatic and effective, that we have developed and employed successfully for more than thirty years.

### **The Substance Abuse Practitioner's Point of View: A Synthesis**

There are life experiences and cultural influences that provide the learned aspects of substance abuse, and, as will be shown in the next chapter, there are cellular changes in the body of the substance abuser over time that are the physiological basis for the insatiable craving and the pain on withdrawal. Pragmatically, it is often impossible to

separate the two components of addiction. Which is the most important? One might as well ask, What is more important when measuring area, length or width? Clearly it is impossible to answer the question as posited, but one can look at individual rectangles and discern that some are long on length and short on width, making the answer for that particular rectangle apparent. There are all manner of rectangles, with varying degrees of length in relation to width, just as there are variations among addicts: some are more influenced by physiology, others more influenced by learning. But let us make no mistake: in every rectangle there is both length and width, and in every addict there are both biological and psychological determinants.

One needs only to stay up one night with a heroin addict who is withdrawing and who is doing it "cold turkey," observing the suffering from both profuse diarrhea and vomiting as well as severely alternating chills and sweat, to be convinced of the physical aspects of withdrawal. Yet denial, which is the most universal and pervasive feature of all addictions, is a psychological phenomenon, as are the effective therapeutic interventions that lead to recovery. Further, the ongoing determination to stay clean (abstinent), known among recovering addicts as surrender, is also a psychological process.

### **What Do the Numbers Say?**

In Chapter Two, we will look at the specifics of drug addiction, including drug preferences, as well as genetic, in utero (prenatal), and environmental-cultural contributors, and finally look at special populations. First, it might be helpful to look at the statistics, enabling the reader to appreciate the specifics of abuse and their extent in the total population.

According to NIDA and the National Institute on Alcoholism and Alcohol Abuse (NIAA), substance abuse is all around us and in a variety of forms. Thirty-five million Americans abuse alcohol, and approximately half that, seventeen million, abuse marijuana. A startling forty million abuse legal drugs, both prescription and over-the-counter varieties. There are three million heroin addicts, and, following a period when heroin addiction was declining, it is once again on the increase. There are four million persons regularly abusing cocaine or crack cocaine, and five million regularly abuse amphetamines (methamphetamines, crystal meth, and so on). Eleven million regularly abuse barbiturates.<sup>2</sup>

Do not attempt to add these up, as there is considerable overlap. Polydrug abuse is the order of the day. Exact numbers are hard to come by, but estimates place chemical dependency in America at a low figure of 15 percent of the total population and a high figure of 20 percent. This means that one in six or one in five Americans is a substance abuser. It bears repeating that 40 to 45 percent of all persons seen by behavioral health specialists have substance abuse problems: either they are addicted, or substance abuse is exacerbating a primary psychological condition.<sup>3</sup> In either case, the substance abuse needs to be addressed as part of treatment. Yet most practitioners rarely address chemical dependency problems, or they take the approach that with continued psychotherapy the chemical dependency will evaporate. Look over your treatment load. In how many cases might you have failed to identify substance abuse? Can you do better?

Perhaps the most significant statistic from NIDA and NIAA is that 71 percent of substance abusers are employed. This means that most will have health insurance, and almost all are potentially in your treatment room, now or in the future. Only 21 percent of substance abusers are unemployed, marginally employed, homeless, or in prison.<sup>4</sup> Under Medicaid even many of these are potentially your patients.

Think for a moment of the implications for your practice. If approximately thirty-five to

forty million Americans are addicted, and 71 percent of these are employed and have health insurance, approximately one in three of the patients who walk into your office are likely to be addicted if you only see patients with employer health insurance, or almost one in two if you see persons covered by Medicaid, Social Security Disability, and Medicare. Are you identifying a number even close to that figure? How many addicts are you failing to even suspect, much less identify?

### **Who Is the Pusher?**

No discussion of the addict would be complete without looking at the question of who is the pusher. For the most part the pusher and the user are one and the same. This means that both the addict and the pusher are sitting unidentified in your office. You will never see the drug lord or the mafioso, the ultimate supplier, who is far removed from the grubby level of hard-core addiction. It is the addict sitting unidentified in your office who, in order to pay for his habit, is forced to become a dealer in drugs. Each addict-dealer obtains a supply, takes out what he needs for personal use, then "steps on" (dilutes) the remainder, which he then sells. The purity or potency of the chemical depends on how often it has been stepped on before the present buyer acquires it. Those far down on the chain are getting low-grade drugs, and when they are lucky enough to get their hands on high-grade heroin, for example, merely taking the usual dosage results in an overdose because of the difference in potency.

It is not unusual that a patient referred to you has been charged with "possession with the intent to sell." The individual may be a stockbroker in an Armani suit, so unlikely to be a pusher that you accept the patient's protestations that this is a mistake. Yet every brokerage house, large law office, and factory-and every other conceivable employment setting-has its addict pusher. You will be referred a twelve-year-old boy who has been accused of selling Ritalin on the school grounds. The parents are outraged, the boy looks angelic, and in your mind you dismiss the allegations as a mistake. Be reminded that nearly a third of the Ritalin prescribed to school children is being resold by these same children.<sup>5</sup> Many of our schools are awash in recycled Ritalin, and the parents are the last to know it.

The images of the crack dealer standing on the corner in the inner city, the "needle man" (heroin dispenser) in the shooting gallery, the "clerk" in the crack house, the outlaw motorcycle gang peddling speed (amphetamines), the furtive grunge lurking near the school, and the "pizza man" who makes the rounds in an unmarked, nondescript old van are the ones that most persons associate with the pusher. If these are the people you are looking for, you are unlikely to see them in your office.

Most large workplaces have at least one employee from whom drugs are readily available, and these are often trusted employers or even members of the executive suite. We have treated a number of highly successful executives and professionals who had introduced cocaine into their law firm, advertising agency, or brokerage house as a way of supporting their own several-hundred-dollars-a-day addiction. One beautiful and hard-driving account executive confessed after her fall to poverty and disgrace that while she was on top, her money went for cocaine, fast cars, and fast men, in that order, all of which had to be supported by peddling cocaine to her coworkers. But even simpler than that, everyone has an acquaintance who is known for being able to obtain for his friends "whatever candy you want."

With all due respect to the medical profession, the pusher is sometimes as close as the kindly physician who has the reputation among users as a "script doctor." These script doctors, although in the minority, are still all too common, and they are well known to addicts through their underground. There are three types. The first is the well-meaning

physician who wants to alleviate all pain and discomfort. This physician overly prescribes pain killers, sleeping pills, and other mind-altering drugs; he is too naive to realize that the addict is the one who always comes in requesting a specific drug and is obtaining prescriptions from a number of other physicians so that no one physician is aware of the extent of the medications the patient is receiving.

The second type of script doctor is the "impaired" (addicted) physician, who because of her own chemical dependency cannot stand to see someone "strung out" (in withdrawal). Addicts present themselves feigning far greater discomfort than they actually feel, easily obtaining a legal prescription to carry them until they can obtain their illegal drug of choice.

The third type is the unscrupulous physician who is actually illegally trafficking in legal drugs. Because he is issuing an enormous number of prescriptions, this physician needs a "cover," such as a specialization in weight reduction, thus ostensibly explaining the large number of daily prescriptions issued for amphetamines. A variation on this unscrupulous type is the physician who purposely addicts the patient so that thereafter this patient is a source of a steady income stream.

In your first session with a patient, be alert when you find out that the person is the patient of any of the foregoing types of physicians. These doctors are well known in the medical community but characteristically ignored by a profession that is reluctant to report a colleague who is suspect.

I (Nick) was the psychologist who was impaneled to treat most impaired physicians in my community. In that role, I saw the unfortunate and the cynical, but I knew when my physician patients were truly in recovery: they no longer overly prescribed to their own patients. My worst experience was the demise of a close friend, a prominent psychiatrist and a past president of the American Psychiatric Association. He was accused by a number of women of having addicted them with weekly intravenous injections of barbiturates (for example, sodium amytal), thus tying them to his expensive practice in perpetuity. They further accused him of raping them while they were under the "twilight sleep" of the drug, which caused me to wonder if he suffered from his own drug-impaired judgment.

I will never know the full story because my friend and colleague denied the charges, but rather than sustaining a hearing by the medical board, he forfeited his license. He was not able to stem the tide of notorious publicity, casting embarrassment on all of us in the behavioral health professions. Of the unfortunately too many times that drug addiction or drug pushing among colleagues has come to my attention, this case is among the saddest for me because of the respect I had for this man's contributions and stature in the field. It remains a constant reminder of how easy it is to miss the problem of substance abuse, especially in the first session.

#### **Notes**

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