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UW ALCOHOLISM AND DRUG ABUSE INSTITUTE NAMES NEW DIRECTOR

Dr. Marc A. Schuckit, Associate Professor of Psychiatry at the University of California Medical School, has been named the first permanent director of the University of Washington's Alcoholism and Drug Abuse Institute The appointment is effective May 1, 1975.

Dr. Schuckit received his medical degree from Washington University Medical School, St. Louis, in 1968 and was given the Hofheimer Award of the American Psychiatric Association in 1972.

The new director has an extensive list of publications dealing particularly with the genetics and epidemiology of alcoholism. Dr. Schuckit considers himself a clinician with a broad range of interests in both alcoholism and drug abuse.

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PLANS FOR 2nd ANNUAL CONFERENCE

The Alcoholism and Drug Abuse Institute staff is continuing the preparations for the 1975 conference *"Behavioral Approaches to Alcoholism and Drug Dependencies."* Scheduled for July 31-August 1 on the University of Washington campus, this meeting will involve as presenters a sizeable number of prominent researchers from a number of major universities. *Peter Nathan* from *Rutgers University* will present the keynote address: *"Behavioral Approaches to the Assessment and Treatment of Problem Drinking: A Critical Overview."* *Don Cahalan* from the *University of California at Berkeley* will speak on *"Implications of American Drinking Practices and Attitudes for Prevention and Treatment of Alcoholism."*

In addition to the formal addresses, in which each speaker will present a general overview of his or her own work, the major speakers and other authorities will lead small-group workshops designed to explain and teach the details of their own specific programs and reseach.

Additional information may be obtained by contacting the Office of Short Courses and Conferences, 327 Lewis Hall, University of Washington, 543-5280.

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ALCOHOLISM AND DRUG COURSES OFFERED THIS SUMMER AT WASHINGTON STATE UNIVERSITY

Two alcohol and drug related courses will be offered this summer at Washington State University. One is Psych/Soc 365, Problems of Alcohol Addiction and Abuse, which is scheduled for a short session of four weeks, June 23 - July 18.

The second course is Pharm 217, Drugs in Our Society, which is scheduled for the regular summer session, June 23 - August 1. Both are core courses in the undergraduate Certificate Program.

For further information about enrollment, write to Dr. Aldora Lee, Alcoholism Studies Program, WSA, Pullman, WA 99163.

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DRUGS AND THE VIETNAM VETERAN

Professor Roger A. Roffman, Acting Director of the U.W. Alcoholism and Drug Abuse Institute, spoke at the Project Veteran '75 Employer Breakfast, hosted by the Mayor's Committee to Aid Returning Veterans, City of Seattle. Professor Roffman's remarks follow:

"In any discussion of the employment situation of veterans, particularly of the younger veterans of the Vietnam-era, the issue of drug abuse is likely to arise. The public seems to have been sensitized to make this kind of a connection, perhaps due to the following reasons:

1. The mid and late 1960's witnessed a rapid increase in the use of illicit drugs among youth in general.
2. Very sensationalized accounts of marijuana smoking among American military personnel in Vietnam appeared in the U.S. press beginning in 1967. These stories tended to spread alarm among members of the U.S. public, and - more importantly - resulted

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Nepenthe (ni-pen'thi), n. (L. Gr. nepenthes, removing sorrow ne-, not + penthos, sorrow, grief) 1. a drug supposed by the ancient Greeks to cause forgetfulness of sorrow, 2. anything causing this state.

in a large-scale military crackdown which virtually set the stage for the lucrative sale of heroin to American soldiers in Vietnam beginning in 1969. Heroin was less bulky, did not have an easily detectable odor, and thus was a safer substance than marijuana for purposes of avoiding detection.

3. The later use of heroin by American military personnel in Vietnam, occuring as it did concurrently with the recent heroin epidemic in the cities back home, led many to anticipate a major menace to public safety and health. And that was the spectre of thousands of soldiers returning from Vietnam with irreversible heroin addiction, doomed to lives of crime in support of their habits, and spreading this terrible affliction as they fed the then out of control epidemic in the U.S.

Needless to say, the issue of drug use in Vietnam was urgent, heavily politicized, and confusing. In order to gain some understanding of the dimensions of the problem, the federal government commissioned a study of the extent and consequences of drug use among Vietnam veterans. Dr. Lee Robins of the Department of Psychiatry in the Washington University School of Medicine was principal investigator for this research.

Approximately 13,760 Army enlisted men returned to the U.S. from Vietnam in September 1971. Of these, approximately 10% had been found to have urines positive for drugs (narcotics, amphetamines, or barbiturates) at time of departure.

From this population of returnees, 1,000 men were selected for study. These men were sought for interviews and urine samples 8 to 12 months following their return. In addition, other data were collected from their military records and from Veterans Administration claim files.

Dr. Robin's final report asked and answered a number of questions, such as the following:

1. What proportion of these Army enlisted men had used illicit drugs in Vietnam? The answer: 45%. Narcotics had been used at least once by 43%; amphetamines by 25%; and barbiturates 23%. 20% of the men reported that they had become addicted to narcotics in Vietnam.

2. What proportion of these men used narcotics in the 8 to 12 months between their return and the interview? The answer: in all, 10% had used narcotics since their return, but only 1% had been addicted since returning.

3. What other drugs did returnees use after Vietnam? Half the returnees had used marijuana. 19% had used amphetamines. 12% had used barbiturates.

In two major ways, these findings were striking. First of all, they dispelled the myth that heroin addiction is chronic and irreversible for most people. Secondly, they clearly showed that for more than half of the people who had used narcotics, addiction never happened.

While 43% of the men had used heroin in Vietnam, only 20% had been addicted there. Since returning home, 10% had used narcotics, but only 1% had been re-addicted.

If all of this sounds like "good news," I'm afraid that there is some "bad news" as well. While only 1% of the men had been addicted since returning, 8% were found to be experiencing serious drinking problems. Of course, statistics can create a somewhat distorted impression depending on the manner in which they are presented. Therefore, we might acknowledge that 99% were not addicted to narcotics and 92% were not problem drinkers or alcoholics.

In closing, I'd like to make several points, and they will reflect my own biases:

1. The phenomenon of drug use among soldiers has always been a politically hot potato. When we differ at home about whether or not to support a particular military intervention, we tend to tremendously over-exaggerate issues such as drug use for the purpose of bolstering our arguments rather than calmly and rationally seeing such use for what it really is.

2. As a consequence, today's Vietnam-era veteran is a victim of sensationalism. He deserves a fairer shake.

3. Today's businessman cannot avoid the fact that, to one degree or another, problems with alcohol and drugs will appear on the job - whether in the Ph.D. or high school drop-out, the young or the near retiree, the executive or the unskilled laborer. The job setting is the ideal place for early intervention and holds the strongest likelihood of successful change. Hopefully, every employer will soon recognize these facts and support the implementation of a program in their work settings.

In the long run, early detection and appropriate intervention with workers having problems with alcohol and drugs will serve the interests of the employer, the worker, and the general public."

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AUSTRALIAN DRINKING PRACTICES

A recent article reported in "The Journal" revealed some shocking statistics on drinking practices in Australia. According to Dr. George Milner, Director of Alcohol and Drug Dependencies Services in Victoria, the average Australian consumes the equivalent of 100 gallons of beer a year and is virtually certain to develop serious alcohol-related medical problems. George Howells, Director-General of Health, reported that in Canberra, nearly

10% of the wages earned by workers is spent on alcohol and tobacco. He also noted that the amount spent on alcohol and tobacco is more than is spent on clothing. From June of 1972 to June of 1973, Australians spent 3.31 billion dollars on alcohol and tobacco while spending 3.16 billion on clothes. The alcohol consumed in Australia during this one year period amounted to 372 million gallons of wine.

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MARIJUANA DECRIMINALIZATION IN WASHINGTON

Substitute House Bill 689 is currently before the House Judiciary Committee, being introduced by Representatives Blair, Thompson, Brown, Conner, Douthwaite, Randell, King, Hurley (George), Haley, Savage, Charnby, Chandler, Williams, Adams, and Peterson.

Provisions of the bill include making distribution of twenty grams or less of marijuana for no remuneration or possession of forty grams or less violations, punishable by a fine not to exceed $100.

The substitute bill added the additional proviso that a repetition of either of the above acts within any two year period would result in the charge of a misdemeanor.

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"MEASUREMENT OF ADAPTIVE ABILITIES AND INTELLECTUAL FUNCTIONING OF HOSPITALIZED ALCOHOLICS": RESEARCH IN PROGRESS

Dr. Michael R. O'Leary, Staff Psychologist with the Veterans Administration Hospital, is principal investigator of this current study being funded by the Alcoholism and Drug Abuse Institute. Dr. O'Leary has written the following brief summary of his research and its implications:

"The crux of the matter is this: for years lay people and professionals have bounced the notion of 'brain damage and alcoholism' around with little apparent understanding of the phenomenon. People doing research in the area could communicate quite readily with one another about performance deficit on this and that test but the guy in the trenches--i.e., alcoholism treatment personnel--have had little understanding of the problem. Often their understanding has been limited to their observations of patients in the end stages of alcoholic deterioration with diagnosible organic brain syndrome.

Our research is primarily an effort to reduce some of the mystification and misunderstanding by: 1) Demonstrating that there are serious and significant cognitive deficits that occur as a result of alcohol abuse that are not detectable by standard I.Q. tests. (This is certainly not original but replicates and extends previous work.) 2) More importantly, putting into demonstrable, clinical use, the concept of the 'Brain Age Quotient' (BAQ) suggested by Reitan.

The BAQ is seen as a single index of current adaptive ability that will have great practical use for the clinician in treatment planning for the individual alcoholic patient. It is very similar to the I.Q. with a mean of 100 and SD of 15, etc., so that all of the complexities of the Halstead-Reitan Battery can be reduced to a number which can be understood in terms of the patient's ability to solve life problems effectively. For instance, if a patient has a reported BAQ of 85, this would mean that he is performing in the lower 15th percentile of a (theoretical) distribution of persons with the same age and education. This gives the clinician an idea of how the person can function in problem solving or his ability to adapt to changing demands of the environment, as compared with normally functioning people. This means that instead of some vague statement like, "The patient scores in the brain damaged range on 'such and such' a test," the clinician has a much clearer understanding of how his patient compares to normals.

I want to reiterate that there is no readily translatable index of impairment available that does not require considerable expertise in psychometrics and assessment of brain damage. Also the standard I.Q. test does not tell us very much about current abilities to function.

The treatment implications are enormous. I will touch on them briefly.

1. Alcoholics may appear more functional than they really are and treatment personnel may generate unrealistic expectations of their performance which can only result in frustration, sense of failure, and lowered self-esteem for the patient.

2. Cognitive and 'insight' oriented therapies may require more verbal mediation or abstract understanding than the patient is capable of mastering. Behavioral and social skill training approaches which stress building coping skills may be a more efficacious form of therapy.

3. Behavior such as implusiveness, low frustration tolerance and 'chronic resentment and irritability' which has previously been attributed to 'personality patterns' may well be the result of diffuse cognitive impairment and an inability to make adaptive changes."

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MARIJUANA: AS DAMAGING AS RECENT REPORTS IMPLY?

Edward Brecher, senior author of Licit and Illicit Drugs (cited by the American Library Association as a book of "outstanding merit" in 1972) has written a strong treatise on the current status of marijuana use and physical health in the March, 1973 Consumer Reports. It reviews the most recent research on some of the physical effects attributed to marijuana use, and the dimensions of the controversy over these findings. It is an important updating of his extensive study of the prevailing scientific, social, and legal evidence on marijuana, in

preparation for the 1972 book. In this article, Brecher summarizes the case against marijuana recently published in reputable scientific journals, and made public knowledge in the Eastland committee hearings, as well as the evidence advanced to the contrary.

Five major kinds of negative physical findings are reviewed: 1) irreversible brain damage and premature cerebral atrophy, 2) lowered resistance to infectious diseases and cancer, 3) chromosomal damage in lymphocytes and the anticipation of possible genetic mutation and birth defects, 4) lung damage and precancerous changes in lung cells, 5) lowered testosterone levels and possible sterility and impotence. These findings were reported last spring during the Senate Internal Security Subcommittee hearings, and Senator Eastland's acceptance of their validity and implications increased their credibility and potential influence on public policy. Brecher seeks to place the findings within a broader research perspective, and to bring into public view other findings which are at variance with them.

In terms of research quality, Brecher finds many of the studies concluding physical damage to be flawed with respect to sample size, randomization procedures, comparability of clinical and control groups, measurement errors, the toxicity of the dose level used relative to amounts used by regular and heavy users, contamination of the study due to multiple drug use by subjects, the attitudes of researchers prior to data collections, the conditions under which data are gathered, the use of imperfect experimental designs, and the low external validity of the findings. Campbell's study, for example, showing cerebral atrophy in young cannabis smokers, used a sample of ten, many of whom were multiple drug users. Heath's study, indicating irreversible brain-wave changes in rhesus monkeys exposed to marijuana smoke, involved dosages sufficiently large to suggest the effect may have been explainable in terms of sheer chemical toxicity rather than to the marijuana per se. No effort to study degree of effect by dose-response level was made, and the concentration of marijuana smoke forced into the monkeys' lungs was vastly greater than that experienced by heavy marijuana smokers.

Findings contrary to Kolansky and Moore's positing of an "amotivational syndrome" in their chronic marijuana-smoking psychotherapy patients, which they felt implied organic brain changes, were found in Grant's study which showed that a battery of the most sensitive neuropsychiatric tests available could not demonstrate significant differences between a sample of 29 moderate marijuana users and controls. These results were similar to a study by Mendelson and Meyer on small comparative samples of casual and heavy users. Brill's research monitored the college grades of 1380 UCLA undergraduates over a year's time, distinguishing six levels of marijuana smokers, all of whom showed steady improvement in college grades Neither resulting college grades nor other factors measured in the study were considered indicative of brain damage or an amotivational syndrome.

With respect to lowered resistance to disease, the results of Silverstein and Lessin's study conflicted with Nahas' research findings that marijuana smokers experienced an impairment of the immune response similar to that found in some cancer patients. Using an immune-reaction skin test to a particular foreign substance as their measuring instrument, they found no impairment in the immune reaction of 22 marijuana smokers and no resemblance between the immune reactions of this group and a comparison group of cancer patients. Tests with other foreign substances supported these findings.

The Stenchever report on chromosomal damage has been heavily challenged by Nichols, who gave his 24 subjects measured doses of marijuana daily over a 12-day period, checking chromosomal conditions before and after, and found no damage. In separate studies, Thorburn, Pace, and Neu failed to find chromosomal damage. In addition, animal studies have not provided such evidence.

Brecher finds two difficulties with the Morishima report in the Eastland hearings, which indicated fewer than normal numbers of chromosomes in lymphocytes of marijuana smokers. The sample size was three, and the 30% discrepancy in numbers of chromosomes between the clinical sample and the controls, says Brecher, was too large not to be noticed by previous researchers.

The evidence on lung damage, Brecher feels, is so far inconclusive. However, research results would favor the theory that it is the amount of smoke inhaled more than the type which is related to lung deterioration. On the subject of sterility and impotence, three efforts to replicate the Kolodny study's findings of low testosterone levels in marijuana smokers failed to yield significant differences between users and nonusers. Mendelson's controlled study of 27 young male casual-to-heavy marijuana smokers showed initial testosterone levels in the upper range of normal and no suppression of these levels at the end of a 31-day experimental period in which marijuana dosage increased to very high levels.

Brecher's careful analysis of the methodological weaknesses of the studies reporting physical damage is not extended, however, to the studies indicating no damage, which are reported largely without attention to sampling design, or methods of data collection. This is not true, though, of his discussion of a Jamaican study commissioned by NIMH in 1970. The report of this study, done in a society where much heavier and more extensive marijuana smoking is culturally acceptable, was published in Jamaica in 1972 but has never been printed in the U.S., although a Netherlands firm recently released an English edition by the original researchers, Rubin and Comitas. Two of the six anthropologists who participated in the research were involved in the initial field research on the effects of marijuana smoking in several rural districts and in an urban slum.

They found that marijuana smoking among field laborers appeared to increase their expenditure of energy but reduced the total amount of work actually accomplished. However, it increased worker's social cohesiveness, interestingly enough producing what the researchers termed a "motivational syndrome." A six-day medical follow-up study was done at the University of Jamaica Hospital using samples of thirty smokers and thirty nonsmokers. The experimental group, with an average smoking history of 17.5 years, was matched with a control group for age and socioeconomic status, but many of the controls were exsmokers and the majority of both groups were also tobacco smokers. The study nevertheless found no significant physical abnormalities related to cannabis use (including lung damage, chromosomal damage, brain wave abnormalities) and no significant deleterious psychiatric or intellectual effects (as measured by the Eysenck personality test, Hamilton Ratings Scale for Depression, and a battery of 19 psychological tests which included measures of intelligence).

Brecher feels confident that a general pattern is beginning to emerge out of the many studies on marijuana use: when there has been an effort to replicate a piece of research which has resulted in a negative finding on the effects of marijuana use, the results of this research have tended to dispel allegations of physical damage; where the measuring instruments have been difficult to replicate--such as the air encephalogram method used by Campbell or the cerebrally-implanted electrodes used by Heath--a repetition of the research is often not done and the original findings therefore persist in their influence. Brecher's view is that public attitudes and social policy are greatly affected by this pattern, which often involves misinformation about the health hazards in marijuana use.

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"ALCOHOL EFFECTS ON FOLATE METABOLISM": RESEARCH IN PROGRESS

Dr. Robert S. Hillman, Director of the U.W. Health Sciences Learning Resources Center and Professor of Medicine, was recently awarded funding by the Alcoholism and Drug Abuse Institute in support of his program of research. Dr. Hillman summarizes his current study as follows:

"Studies of the effect of alcohol on the metabolic pathways of vitamins have revealed a dramatic interaction between alcohol ingestion and the induction of vitamin deficient states. Two vitamins, folic acid and pyridoxine, are prime targets of the 'toxic' effect of alcohol; this results in organ damage, including an inability of key tissues and organs to replace damaged cells. Because of the rapid turnover of cells and the need for daily production of large numbers of new cells, the bone marrow and red blood cell system is a primary target of acute or chronic alcohol ingestion. Just how the alcohol affects the internal metabolism of these vitamins has been a major interest of several laboratories during the last ten years. In my laboratory at the University of Washington, a prime objective has been to use an extensive experience in characterizing the cellular physiology of the bone marrow to look at potential sites of alcohol effect in vitamin absorption, storage, subsequent release to tissues and, finally, wastage by various excretory routes. The objective of this work has been to identify the specific point in the sequence of uptake and utilization of vitamins where alcohol exerts its destructive effect. The work has now been in progress for more than seven years with major support from the National Institute of Mental Health. The support provided by the State funds for alcohol research were used for one of many studies aimed at characterizing a potential alcohol effect on storage of vitamins, especially folic acid, in liver storage sites.

The potential significance of this work is great. Vitamin deficiencies clearly result in tissue and organ damage. Thus, the definition of specific alcohol effects on the biochemical pathways of vitamins can in the future lead to interventions which will prevent disruption of tissue functions and, possibly, slow organ damage. Since organ damage, especially liver and brain damage, are the prime medical complications of alcoholism, methods for prevention of such damage are ultimately worthwhile."

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THE MEDIATING EFFECT OF ATTITUDES AND BELIEFS ON PSYCHOTHERAPEUTIC DRUG USE

At the May, 1974 Conference on the Prescribing and Use of Anti-Anxiety Drugs, an interesting paper presented by Ira Cisin, Dean Manheimer, and Susan Davidson investigated the extent to which attitudes and beliefs held about psychotherapeutic drugs are related to their use--over and above the relationships already shown by studies to exist between drug use patterns and particular variables such as age, sex, and level of psychic distress. Their point of view was that, far from conforming to the usual "preference model" of market research, psychotherapeutic drug use tends to involve an intricate process: the perception of distress of a psychic, somatic, or psychosomatic nature; the decision to cope with such distress through a physician rather than other means; involvement in a particular facilitating or discouraging physician-patient attitude environment; the decision to have the prescription filled; the actual use of the drug. If level of psychic distress, age, and sex, were held reasonably constant, the question the authors posed was what precise function would personal attitudes and cultural values have in mediating drug use?

Their inferences were based on a portion of the data from a national survey on psychic distress, life crises, and drug use completed by the authors in 1973. This survey indicated that Americans believe in the efficacy of prescription psychoactive drugs, but not necessarily in the morality surrounding their use--that is, whether the use of such drugs is compatible with certain cultural values associated with individualism and the Protestant Ethic. Within the survey data

they were interested primarily in two groups of people: those with high psychic distress but an insignificant degree of prescription drug use, and those with little or no perceived distress but high drug use. Out of the original nine items measuring attitudes toward tranquilizers, an index based on the three items most highly predictive of tranquilizer use in the high distress group was used in a multivariate analysis of non-user and user samples, standardized by sex and age groupings.

The authors found that among distressed persons who evidence highly favorable attitudes toward tranquilizers (on all three items), 68% had used them in the past year; whereas only 17% of those persons in the high distress group with highly unfavorable attitudes had used them. Of those in the high distress group who held generally favorable attitudes (favorable on two out of the three items), 57% had used tranquilizers in the past year compared with 23% in the group with generally unfavorable attitudes.

A similar analysis of the low psychic distress sample showed that 26% of those with highly favorable attitudes had used tranquilizers in the past year, contrasted with only 6% who had highly unfavorable attitudes. The same pattern held for those who had generally favorable and unfavorable attitudes. The authors conclude that at both high and low levels of perceived psychic distress, the quality of attitudes appears to be strongly related to the decision to use or not use prescription tranquilizers. Analysis of the data indicated further that the deterrent effect of negative attitudes among people with high stress may be stronger than the facilitating effect of favorable attitudes among people with low stress, in explaining drug use. The variance accounted for by attitudes was 18% for those with high psychic distress compared with 7% for people with little or no perceived distress. The authors cautioned, however, that the data used were based on the use of tranquilizers and daytime sedatives only, and were time-limited in the sense of determining whether attitudes preceded or were followed by the use or non-use of such drugs.

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DRUG ABUSE AND CRIME: ARE THEY TRULY RELATED?

Joy Mott, a senior research officer of Britain's Home Office Research Unit, recently suggested that the association between crime and drug abuse seems to reflect more the social characteristics of the misusers than the effects of the drug (as reported in "The Journal"). Ms. Mott was speaking to the 11th Conference of Directors of Criminological Research Institutes in Strasbourg, France. She stated that the characteristics of drug offenders have been found to be very similar to those of offenders in general and very different from those of self-reported drug abusers. The social characteristics of offenders who became drug abusers and who continue to abuse drugs are more similar to those of offenders in general than those of self-reported abusers.

Speaking more specifically about various drugs, Ms. Mott said that "apart from the possible effects of cannabis intoxication on driving behavior, there is little evidence in international research to suggest that, for the great majority of cannabis misusers, their misuse has any direct or indirect criminogenic effects as far as non-drug offenses are concerned." Ms. Mott further stated that this situation may change as more potent preparations become available.

Ms. Mott and Marilyn Taylor conducted an investigation of opiate addicts in the United Kingdom and found that prior to any admitted drug abuse, 69% of all offenses were for theft, compared to 31% in the two year study period after formal identification as addicts. The authors concluded that there is no doubt that drug use (opiate use in this case) modifies the criminal histories of the offenders to include mostly drug charges. Mott and Taylor also found no correlation between drug abuse and violence. Ms. Mott's final conclusion was that "the only psychological variable which has been consistently shown to discriminate drug misusers from both the offender and the general population is intelligence. Drug misusers, whether or not they are also offenders, tend to score about average on standard tests of intelligence."

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COCAINE: IS IT REALLY THE "CHAMPAGNE" OF DRUGS?

In the Winter, 1975 issue of Addictions, published by the Addiction Research Foundation of Ontario, Ann Crittenden and Michael Ruby say it is. In a companion article, Dr. Oriana Kalant suggests some weaknesses in their journalistic mystique. Nevertheless, the head of the U.S. Drug Enforcement Agency has termed cocaine the most popular drug in America in the mid-70's. Federal statistics show a seven-fold increase in cocaine seizures between 1969 and 1974. A survey taken for the Commission on Marijuana and Drug Abuse reveals that in 1972, 10.4% of all college students had taken cocaine at least once. Crittenden and Ruby, however, claim its users encompass all social and economic categories.

Its champagne reputation, though, attaches to its use concentration among what one drug abuse specialist calls "the glitter people." It also reflects the attitudes surrounding its use, such as the expectation that one can achieve a good high without the consequences of intravenous heroin or the less predictable hallucinogens, the apparent absence of pharmacologic tolerance and withdrawal symptoms with chronic use, rapid metabolism in the body making detection difficult, the rarity of overdoses, and the lower association of its use with criminal activity to support a habit. Despite a long history, and the current increased use, the authors point out that there have been virtually no studies of cocaine's effects on humans since Freud, nor any research comparing the effects

of cocaine and the stronger amphetamines. The National Institute of Mental Health and the National Institute on Drug Abuse have only recently begun to encourage controlled, clinical experimentation with cocaine.

Taken internally, it is thought that cocaine potentiates the effects of norepinephrine by preventing its reabsorption, thus mimicking adrenaline with its peripheral nervous system symptoms of vasoconstriction, elevated heart rate and blood pressure, and dilated pupils. As a central nervous system stimulant, it produces feelings of euphoria and increased energy, the postponement of fatigue and the inhibition of appetite. To Dr. Kalant, it is nearly identical in pharmacological effect to the amphetamines, a point she feels is underemphasized in the Crittenden-Ruby article, and therefore affords the same hazards at high doses in terms of psychological dependence, the development of paranoid psychosis and bizarre, erratic, and often violent behavior. In creating a sense of mystery and glamour about this newly-rediscovered drug, and in failing to give a complete historical perspective on its use, she says of the preceding article, journalists may not only mirror but create public attitudes which increase the use of drugs like cocaine, without full knowledge of their potential for abuse. She gives as an example the attention given to the low incidence of deaths by overdose, and suggests this ignores the fact that deaths due to accidents, suicides, and homicides are higher among heavy amphetamine users (and in all probability among heavy cocaine users) than in the general population. Strong psychological dependence on cocaine, she adds, is accompanied by a myriad of mental and physical health problems.

Neither article takes a position on whether the government should try to cork this bubbly, but it is clear that both articles take a bit of the sparkle out of the bottle.

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ALCOHOLISM PREVENTION: A MYTH?

A common theme in alcoholism programs and educational presentations is that of the "importance and need of programs on prevention." Melvyn Kalb, Ph.D., of the Santa Clara County Mental Health Alcohol Services Division, believes that alcoholism prevention is essentially a mythical dream with the methods that exist at this time.

Dr. Kalb contends that there are three basic myths in the prevention of alcoholism. He refutes the notions that: 1) awareness of facts about alcohol leads to changes in drinking behavior; 2) prevention programs centered around consequences are effective in producing changes; 3) application of the primary and secondary prevention model to alcohol education is valid.

In support of his arguments, he cites numerous cases in which public educational campaigns have failed to change existing behaviors, as in the cases of anti-smoking programs, seat belt use, etc.

The implication of his argument is that preventive programs about alcoholism must be directed to a different audience; not the hard-core alcoholic or persons with rigid ideas about alcoholism, but instead toward an audience whose attitudes about alcohol are still forming, and thus truly to prevent the need to change behaviors in the future.

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GRIEF-WORK

Dr. Lester R. Bellwood, Chief of the Alcoholism Division at Fort Logan Mental Health Center in Denver, recently presented a paper entitled, "Alcoholics Need to Do Grief-Work." He offers some thought-provoking arguments toward the use of a grief-model in looking at and treating alcoholism.

He outlines two premises to his discussion: 1) that 20% of all alcoholic clients treated at his Institute state that they began drinking when they suffered a major loss or separation, thus did not go through the normal grieving process at the time, and a serious need to do grief-work persists, and 2) alcoholics are in a chronic state of grief secondary to continuous losses.

Dr. Bellwood maintains that normal grieving in reaction to losses of any sort is "pain with purpose." He identifies three major stages in the grieving process: depression, anger, and reconstruction.

Alcoholism is, in his opinion, a form of abnormal grief. Treatment consists of helping the person to be able to do the constructive work of mourning.

The need to do grief-work is too often overlooked as part of a treatment program for alcoholism, and also in the crucial times the person will encounter after completing a program. Dr. Bellwood suggests that grief-work groups be a part of therapy and follow-up for the alcoholic person.

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University of Washington Alcoholism and Drug Abuse Institute Research Forums:

Friday, May 23, 1975 -- *"Social Factors in the Etiology of Alcoholism"* presented by Claude M. Steele, Ph.D., Assistant Professor, Dept. of Psychology. Location: H.S. T-639, 12:00-1:30 pm.

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Nepenthe Staff: Roger A. Roffman, Assistant Professor of Social Work & Acting Director, ADAI, and Aldora Lee, Coordinator, Alcoholism Certificate Program, WSU -- Co-Editors. Staff: Ann Blalock, Scott Blume, Barry Caudill, Howard Crockett, Ron Jackson, Jane Ramsey and Kathleen Yantis.

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