ASAMNEWS

Special Report on METH-AMPHETAMINE see page 6

Volume 11, No. 1 January / February / March / 1996

Newsletter of The American Society of Addiction Medicine

ASAM Acts to Support FDA's Tobacco Initiative

John Slade, M.D.

ASAM is working in support of the Food and Drug Administration's efforts to regulate tobacco products as nicotine delivery devices.

FDA proposed its new regulations for cigarettes and smokeless tobacco products that contain nicotine in an announcement in August 1995. Specific measures included in the proposal include regulations forbidding sales to minors, banning advertising targeted to minors, and requiring that tobacco manufacturers pay for advertising to discourage young people from use of tobacco products.

The proposal triggered a major campaign by the tobacco industry to forestall regulation, involving media offensives, a flood of letters to FDA opposing the proposed regulations, four separate lawsuits against FDA, and calls by some members of Congress for curbs on FDA regulatory authority.

On January 2, 1996 — the last day of the public comment period — ASAM EVP James F. Callahan, D.P.A., delivered four banker's boxes of materials to the FDA's offices in Rockville, MD. The boxes contained ASAM's comments on the agency proposal, along with 19 binders of supporting materials, including tobacco product promotional items such as a Benson & Hedges cap, some Camel lighters and a Newport T-shirt.

Prepared for ASAM by John Slade, M.D., with assistance from Devra Keenan and support from the Robert Wood Johnson Foundation, the commentary supports FDA's assertion of jurisdiction over cigarettes and smokeless tobacco products. It also suggested a number of ways in which the proposed regulations could be strengthened.

For example, ASAM proposed that tobacco companies be required to report annually to FDA results of surveys showing the number of young people who regularly use the company's brands. In this way, corporate management, shareholders, employees and the public could estimate the size of the youth population using the company's products, as well as any progress made in reducing such use (which the major tobacco manufacturers all profess that they wish to do).

Dwarfing ASAM's comment was a 2,000 page submission by the major cigarette companies, accompanied by more than 40,000 pages of supporting material. FDA staff must digest the huge volume of comment material before publishing its final rule.

The tobacco industry is widely expected to mount legal challenges to any final rule on all possible fronts, and the Congress likely will consider measures this Spring that would prevent FDA playing a role in tobacco product regulation.

ASAM: FDA should play a key role in fighting tobacco-caused diseases

Interested members of ASAM should contact their Senators and Representatives to express their views on tobacco regulation. Since 1988, ASAM's position has been that the FDA should play a key role in fighting the epidemic of tobacco-caused diseases. While the Society is optimistic that this long-standing policy now has a chance of being implemented, such a positive result will occur only if all people concerned about nicotine addiction show their support. (See page 4 for the full text of ASAM's cover letter to Dr. Kessler.)

(Dr. Slade chairs the ASAM Nicotine Dependence Committee.)

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ASAM
American Society
of
Addiction Medicine

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ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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EXECUTIVE VICE PRESIDENT'S REPORT

ASAM MEETS WITH ADM LEADERS IN PORTUGAL

The Portuguese Addiction Medicine Association (APMA) held its first annual Medical-Scientific Conference on addiction prevention and treatment December 5-7 in Lisbon, Portugal. Joaquim Carrilho, M.D., ASAM member and APMA President, signaled his strong interest in close collaboration between ASAM and APMA by inviting ASAM officials to participate in the conference. ASAM President David E. Smith, M.D.; members Timmon Cermak, M.D., Raymond Deutsch, M.D., Stanley Gitlow, M.D., and John Slade, M.D.; and EVP James F. Callahan, D.P.A., to serve as members of an international faculty for the event.

More than 150 physicians, nurses, social workers, counselors, administrators and representatives of government and the pharmaceutical industry participated in the three-day event. The U.S. embassy was represented by USIS Counselor of Embassy Kathleen Brian, while Rev. Feytor Pinto represented the Portuguese government and served as Vatican envoy.

The ASAM delegation also participated in a special APMA/ASAM conference dinner, during which the group discussed how ASAM and APMA can work together to promote development of addiction medicine organizations in other nations. During the dinner, Dr. Smith offered greetings from the ASAM Board of Directors and members worldwide, and presented Dr. Carrilho with a framed certificate, which was inscribed with the message:

> *In recognition of the convening of the Association's First Addiction Medicine Annual International Medical-Scientific Conference, and in recognition of the Association's goals of fostering and disseminating knowledge and research in the addictive diseases, increasing the standards for medical care for people affected by the diseases, and providing a forum in which both doctors and medical students may learn the art and science of addiction medicine and foster compassionate understanding of, and expert treatment for, persons who suffer from the diseases of alcoholism and other drug dependencies.*

At a gala awards dinner, Dr. Callahan presented APMA with a copy of *Principles of Addiction Medicine.* APMA has 50 members, with a membership goal of 100 in 1996. APMA reprinted and distributed 10,000 copies of the ASAM/NCA definition of alcoholism (JAMA, August 26, 1992, Vol. 268, No. 8).

L to R: ASAM President David E. Smith, M.D.; Vatican envoy and government representative Rev. Feytor Pinto; APMA President and ASAM member Joaquim Carrilho, M.D.; and ASAM EVP James F. Callahan, D.P.A. (Photo by David E. Smith, M.D.)

AMA TAKES MIXED STAND ON TOBACCO POLICIES

Emanuel M. Steindler, M.S.

ASAM got somewhat less than half a loaf at the AMA Interim Meeting December 3-6 in Washington, D.C., as the House of Delegates approved portions of the first of two tobacco resolutions the Society submitted, but sliced off other portions and did not adopt the second.

Partially approved was ASAM's six-part resolution seeking to strengthen AMA tobacco policies in the wake of a July JAMA report that documented the tobacco industry's cover-up of the addictive and carcinogenic effects of tobacco use [also see the November-December 1995 issue of ASAM News]. The House endorsed elements of the resolution that asked AMA to (1) support increased funding for government research on tobacco-related diseases and tobacco control efforts; (2) encourage legal action against the industry to recover damages resulting from tobacco-related diseases; and (3) work for the prevention of tobacco exports.

It declined, however, to accept three other proposals in the ASAM resolution that would have (1) prohibited the AMA from taking funds from any division of a tobacco company; (2) put the AMA on record as supporting the elimination of all tobacco advertising; and (3) sought action by the Justice Department to enforce the ban on cigarette advertising in the broadcast media, including sponsorship of sports events. Instead, the House reaffirmed existing policies that stop short of an outright advertising ban, and that explicitly exempt from AMA's "unacceptable-for-support" list tobacco company divisions that do not "produce or market tobacco products" or do not contribute to their "promotion, sale or use."

The other resolution submitted by ASAM asked for endorsement of an educational and treatment approach to underage tobacco users. It was prompted by an editorial in the July 19 issue of JAMA signed by AMA officials, in which they asserted, in one of a series of proposed action steps, that "underage use of tobacco should carry consequences for the user." The House chose to reaffirm existing AMA policy on underage use, which is neither punitive nor a call for treatment.

In related actions, delegates voted to support the right of local jurisdictions to enact tobacco regulations stricter than those in state law, and also to support inclusion of a performance measure on tobacco use in the next revision of the Health Plan Employer Data and Information Set (HEDIS).

Serving as ASAM delegate pro tem at the meeting was Michael M. Miller, M.D. He replaced Jess W. Bromley, M.D., who had served as delegate since 1988, when ASAM was accepted into membership in the House. Intending to retire after the December meeting, Dr. Bromley was unable to attend because of illness. His years of valuable service were recognized on the floor of the House, as well as at a meeting of the AMA Section Council on Preventive Medicine, in whose sessions Dr. Bromley regularly participated as ASAM's representative.

Stuart Gitlow, M.D., was ASAM's alternate delegate pro tem, in the absence of David E. Smith, M.D., and testified as ASAM's spokesperson during Reference Committee hearings. He also participated as ASAM's representative at the meeting of the Young Physician's Section.

In other business of interest to ASAM and its members, the House took the following actions:

- Referred to the Board of Trustees a resolution urging the deregulation of syringes and needles in the nine states that now require prescriptions for such items.

- Referred to the Board of Trustees a resolution calling for an AMA model statute that would authorize a physician to prescribe or administer controlled drugs for the treatment of intractable pain.

- Referred to the Board a resolution from Hawaii seeking a national blood alcohol limit of .02. (Current AMA and ASAM policies call for a .05 BAC limit.)

- Referred to the Board a resolution calling for the AMA to study the relationship between violence and drug use, as well as the potential effects on this relationship of "decriminalization of illicit drugs." A member of the AMA Council on Scientific Affairs testified that this issue already was under study by the CSA.

Mr. Steindler is retired as Executive Director of ASAM and as Director of the AMA Department of Mental Health.

ASAM SUPPORTS NEW FEDERAL DRUG CZAR

Tipper Gore, wife of Vice President Al Gore, invited ASAM to attend a reception introducing Gen. Barry McCaffrey, recently nominated by President Clinton for the post of Director of the Office of National Drug Control Policy. Dr. James F. Callahan, who represented ASAM at the meeting, reports that "Mrs. Gore assured the assembled group of about 25 that she continues to be personally committed to prevention and treatment of addiction, and that the General shares that commitment."

During the 90-minute session, Gen. McCaffrey pledged to be an advocate for drug and alcohol treatment, noting that "the best way I can explain it to Congress in a way they will understand is to say that 'if Congress is serious about reducing crime, you must commit yourselves to giving addiction treatment high priority'."

Gen. McCaffrey was confirmed by the Senate in early March; ASAM sent letters endorsing Gen. McCaffrey to Judiciary Committee leaders Sens. Orrin Hatch (R-UT) and Joseph Biden (D-DE).

FROM THE PRESIDENT

Dear Colleague:

As Dr. John Slade has reported in the article on page 1, ASAM is supportive of the FDA's efforts to regulate cigarettes and other tobacco products. Following is the letter I wrote to introduce ASAM's official comments on the proposed rules.

To the Honorable David A. Kessler, M.D., Commissioner
U.S. Food and Drug Administration

Dear Dr. Kessler:

The American Society of Addiction Medicine (ASAM) fully supports the FDA in its determination that the nicotine in cigarettes and smokeless tobacco products are drugs, and that cigarettes and smokeless tobacco products that contain nicotine are drugs and nicotine delivery devices. The regulatory framework described in the Federal Register of August 11, 1995, for these nicotine delivery devices represents a major advance for public health in the United States. The Society supports the enactment of the Agency's proposal in substantially the same form as it has been proposed, but as the enclosed comment indicates, there are some parts of the proposal that ASAM believes should be strengthened. . . .

Nicotine addiction is the most serious addiction problem in the nation because of the vast number of people affected and the enormous suffering it causes. As you have so rightly said, it is a pediatric disease.

It saddens me to report that my fifteen-year-old son is among those who are addicted to nicotine. He has expressed mistaken beliefs to my wife and me about the safety of cigarette brands that promote themselves as being "natural" and as containing no additives, suggesting that these characteristics seem to him to be assurances of safety. He has received cigarette promotional material in the mail, addressed to him personally from Philip Morris. These are but a few of the tobacco industry's marketing practices that I hope, both personally and on behalf of ASAM, the FDA brings under control through these regulations.

The Society's comments on the Agency's proposal are in three parts. Part A discusses the Agency's assertion of jurisdiction over cigarettes and smokeless tobacco products . . . , while Part B considers the proposed regulation and its supporting materials as published in the Federal Register of August 11, 1995. . . . Both of these comments are accompanied by extensive appendices. Part C, two copies of which are included, is responsive to the Agency's request for comment on the focus group testing of the brief statements [warning of health hazards] it described in the Federal Register of December 1, 1995. . . .

ASAM is grateful for your courage, determination and deep understanding of the issues that have created and perpetuated the tobacco epidemic. The Society looks forward to continuing its support of your efforts to reduce the terrible toll of addiction, disease and death that tobacco products bring to all too many people.

Sincerely yours,

David E. Smith, M.D.
President

ASAM Launches Membership Campaign

ASAM's 1996-1997 International Membership Campaign, chaired by Paul H. Earley, M.D., has announced a new incentive plan for ASAM members who recruit new members. As announced by Dr. Earley and Team Captains Gary Olbrich, M.D., P. Joseph Frawley, M.D., and William B. Hawthorne, M.D., the incentives are as follows:

If you recruit:	**Your award is:**
1-2 new members	ASAM pin and an announcement in *ASAM News*
3-5 new members	ASAM mouse pad and an announcement in *ASAM News*
6-9 new members	ASAM clock, free one-year membership, and an announcement in *ASAM News*
10 new members	"TOP RECRUITERS": ASAM T-shirt, free one-year membership, free Med-Sci Conference registration, VIP seating at the Annual Meeting, and an announcement in *ASAM News* and the Annual Meeting program.

Information on the free membership recruitment kit is available from Theresa McAuliffe, Director of Membership, at the ASAM office.

ASAM MEMBERS ASKED TO COMPLETE CME SURVEY

James A. Halikas, M.D.

ASAM is required by the Accreditation Council for Continuing Medical Education (ACCME) to periodically review the extent to which its CME mission is being achieved by its educational activities. Accordingly, the CME committee asks ASAM members to respond to the following survey, so that the Committee can evaluate its overall CME program efforts. The educational mission of ASAM, through the CME Committee, is to provide physicians with educational experiences of high quality. These experiences should:

- Enhance appropriate physician-patient relationships and appropriate physician attitudes, both in the general field of medicine and in the field of Addiction Medicine
- Help define the field of Addiction Medicine
- Impart new knowledge of the basic sciences and clinical sciences
- Impart new knowledge of the treatment of special populations
- Impart new knowledge regarding epidemiologic, sociologic, cultural and community factors in the addictions
- Teach new skills for the treatment of patients who have addictions
- Stimulate the early recognition and treatment of the addictions
- Stimulate the recognition of the importance of prevention strategies

Please complete this survey and return it by March 30, 1996 to ASAM/CME, 12 West 21st Street, New York, NY 10010 or FAX to (212) 627-9540.

Are you satisfied with the educational activities that are being sponsored/jointly sponsored by ASAM nationally?	YES NO
Have you participated in, or attended any educational activities in the last 18 months? If so, which one(s)?	YES NO
Do you feel that the educational activity in which you participated met its own stated objectives? Do you feel that the activity enhanced your professional skills or effectiveness?	YES NO YES NO
If you have not attended any educational activities of ASAM within the last 18 months, what suggestions do you have for new activities that you would wish to participate in? _____ _____ _____	
Whether you have or have not attended any educational activities, what educational activity do you think ASAM has been most successful in presenting, and what has been least effectively presented? _____ _____ _____	

Additional Comments:

Thank you for your feedback. **Print name:** _____

FOCUS ON . . . METHAMPHETAMINE

METHAMPHETAMINE: AN OLD PROBLEM RETURNS

David E. Smith, M.D.
Gantt P. Galloway, Pharm.D.
Richard B. Seymour, M.A.

[Note to Readers: The topic of this month's "Focus On" is prompted by recent calls to the ASAM office regarding methamphetamine, which ASAM members report seeing with growing frequency. Reader suggestions for future "Focus On" topics are welcomed; please send your suggestions to the ASAM office to the attention of the Editor.]

Methamphetamine (MA) abuse is a serious problem in the United States that has historically occurred in waves resembling patterns seen in epidemics of infectious diseases (Ellinwood, 1974; CEWG, 1995). Emergency room episodes involving MA have more than tripled over the past three years, rising from 4,900 in 1991 to 17,400 in 1994 (Greenblatt, Gfoerer & Melnick, 1995).

Epidemiology

Methamphetamine has made major inroads in western and West Coast cities, and has appeared recently in Iowa, Louisiana and Georgia as well, according to a report by the Community Epidemiology Work Group of the National Institute on Drug Abuse.

CEWG epidemiologists say that methamphetamine formerly was a marginal drug in metropolitan areas, and was confined largely to rural areas and discrete population groups. Users were overwhelmingly white truckers, some gay men, and bikers (who also produced the drug in small batches). Now, however, there are indications that the market is expanding to include black and Hispanic users. In fact, the drug is being produced in bulk by criminal organizations composed of Mexican nationals, using precursor chemicals from Mexico, where they are more easily acquired.

Besides appearing in cities, methamphetamine continues to be prevalent in rural areas of Minnesota and Missouri, and is widespread in Arizona and Colorado.

Like heroin, methamphetamine is developing a new, younger following (Hunt, 1995). As such, epidemiologists report that it may emerge as a substitute for the crack cocaine market in some areas: its "high" lasts longer, its price and profitability are similar, and its purity is more consistent than crack. For some, methamphetamine's "Made in the U.S.A." image may add cachet (CEWG, 1995).

Patterns of Use

Like heroin and cocaine, methamphetamine can be snorted, injected or smoked. A single mode of administration may dominate in a particular geographic area. In San Diego, for example, snorting predominates, while in Denver, injection is preferred. In Honolulu, "ice" is the most popular form. (Ice is a large, usually clear crystal of high purity that is smoked in a glass pipe like crack cocaine. The smoke is odorless and leaves a residue that can be resmoked; its effects may continue for up to 12 hours [Fischman, 1995]). All three modes of administration are seen in Los Angeles and San Francisco (CEWG, 1995).

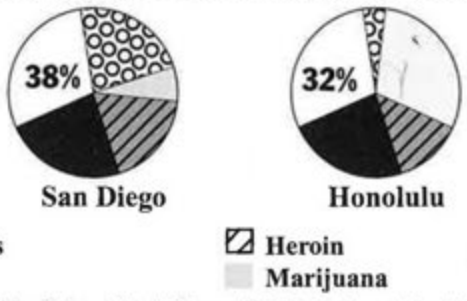
Drug Effects

In general, stimulant users seek a variety of effects, including euphoria without sedation, relief from fatigue, and feelings of energy, confidence and alertness. As the dose rises, pleasurable effects give way to intense anxiety (feeling "edgy" or "wired") and possibly to repetitive motor behavior. Chronic use (even at low doses) can be marked by suspiciousness, hypervigilance, frank paranoia and, in susceptible persons, to violence (Senay, 1983; Smith & Seymour, 1987).

While methamphetamine is similar in chemical structure to amphetamine, it has more pronounced effects on the central nervous system (CNS). Orally ingested MA produces increased activity, decreased appetite and a general sense of well-being. Injected intravenously MA produces a "rush."

Methamphetamine dependence is characterized by anergia, depressed mood and hypersomnia (Smith, 1969; Watson, Hartman & Schildkraut, 1972). These symptoms and the stimulant psychosis generally resolve with abstinence, but

Stimulants as a proportion of primary drugs of abuse among treatment admissions (excluding alcohol) in two cities, 1994



Source community Epidemiology Work Group (1995). Epidemiologic Trends in Drug Abuse, Advance Report. Rockville, MD: National Institute on Drug Abouse, 1995

they can reappear if the patient relapses to methamphetamine use.

Medical Complications

Although not frequent, death from cardiac arrhythmias occurs in stimulant abusers. Large doses may lead to hyperthermia which, when it occurs, constitutes a serious medical emergency. More commonly, any CNS stimulant use may aggravate pre-existing hypertension or, in susceptible users, may trigger a severe hypertensive episode (Senay, 1983).

ATLANTA: "Methamphetamine tends to be used only by white middle-class teenagers and young adults who have no links to the crack scene . . . In rural areas, methamphetamine has come to be called 'redneck cocaine'." CEWG, 1995

In addition, many stimulant abusers experience medical problems associated with injection drug use, including hepatitis, deposition of filler material in the lungs, endocarditis, septicemia and, of course, HIV infection.

Methamphetamine abuse is strongly associated with increased risk of HIV transmission for several reasons. First, a significant proportion (26 to 42 percent in recent studies) of methamphetamine abusers engage in injection drug use (Pearce, 1993; Flynn, Anderson, Clancy & Britton, 1995). Given the large number of new methamphetamine abusers, the number of injecting users is expected to rise equally rapidly.

Second, methamphetamine and related CNS stimulants appear to increase libido (Bell & Trethowan, 1961; Gawin, 1978; Smith, Buxton & Damman, 1979). Moreover, methamphetamine use often causes delayed ejaculation and may be associated with rough sex, both of which factors contribute to the development of abrasions and bleeding. Rougher and prolonged sexual activity also may explain the documented association between methamphetamine use and condom failure.

TEXAS: Street addicts report that methamphetamine "is everywhere." CEWG, 1995

The confluence of injection and sexual behavior risk factors has resulted in an HIV seroposivity rate of 11 percent in out-of-treatment heterosexual methamphetamine abusers in the Sacramento area, compared to 4 percent seropositives among opiate users (Flynn, Anderson, Clancy & Britton, 1995). In a Seattle study (Harris, Thiede, McGough & Gordon, 1993), the seroposivity rate reported among methamphetamine injectors was four times higher than among heroin injectors.

Fetal Exposure

Amphetamine (and presumably methamphetamine) abuse appears to have a damaging effect on the unborn fetus, as manifested by weight and developmental difficulties in the newborn similar to those in infants exposed to crack cocaine (Fischman, 1995).

Psychiatric Disorders

At the cellular level, neuroadaptation to repeated over-stimulation of catecholamine pathways is likely to result in changes in both psychological and intellectual functioning that persist even after drug use is stopped. Agitation, paranoia and violence are the psychiatric problems most commonly encountered in stimulant abusers (Senay, 1983).

DENVER: "In suburban areas, the methamphetamine is purchased in rock form and is smoked in crack pipes using hand-held torches." CEWG, 1995

It has been postulated that stimulant abuse, in at least a subset of users, may be an attempt to self-medicate an underlying depressive disorder (Khantzian, 1985; Little, 1993) or an adult attention deficit disorder (Matochik et al, 1994). In those for whom this is an etiolog factor, proper diagnosis and treatment of the underlying psychiatric disorder (in concert with treatment of the chemical dependence) has been shown to substantially improve outcomes (Evans & Sullivan, 1990).

Independent of pre-morbid status, if methamphetamine abusers develop, over time, a characteristic pattern of pathology or impairment that lends itself to psychiatric intervention, identification of such consequences should help clinicians to develop optimum treatment strategies. The prevalence, severity and persistence of neuropsychiatric impairment have important implications for the design and implementation of cognitively based interventions, whether aimed at high-risk behaviors or underlying methamphetamine dependence.

Treatment Strategies

Therapeutically, it is important to reduce severe symptoms as rapidly as possible because of the reassurance given to the patient by doing so. A regimen that includes pharmacologic as well as psychologic measures is optimal (Senay, 1983).

SAN DIEGO: Methamphetamine is "popular with adolescent females because of its anorexic properties. It is popular with construction workers and truck drivers because the drug enables them to work long, tedious hours without fatiguing." CEWG, 1995

Use of antipsychotic medications such as haloperidol (Haldol) to manage acute amphetamine psychoses, and antianxiety drugs (such as benzodiazepines) for acute stimulant-induced panic attacks, is well-established. However, the value of anti-craving medications post-detoxification has not been established. Specific relapse prevention techniques in amphetamine recovery support groups appear to be effective adjuncts to long-term recovery.

(Dr. Smith, Dr. Galloway and Mr. Seymour are affiliated with the Haight-Ashbury Free Clinics, San Francisco, CA.)

[Complete reference citations for this report are available on request from the ASAM office; write or fax c/o the Editor.]

STATE CHAPTER NEWS

NOTE: Many ASAM state chapters have scheduled meetings during the ASAM Medical-Scientific Conference in Atlanta, most on Sunday morning, April 21. Consult the conference TV monitors on-site.

ARKANSAS

James Tutton, M.D., newly elected President of the Arkansas Chapter, reports that the chapter has had four excellent speakers during its quarterly meetings (which offer CME credits). Most recently, Doug Cook, M.D., presented on the role of spouses and significant others in the recovery process. At other recent meetings, Bruce Carruth, Ph.D., spoke on suppression of feeling in the addicted patient, ASAM President-Elect G. Douglas Talbott, M.D., served as faculty for a two-day symposium, and Carlton Erickson, Ph.D., discussed the neurotransmitter theory of addiction.

The Arkansas Chapter meets the second Sunday of each month at 2:30 p.m. at the Wolfe Street Center in Little Rock. All Arkansas ASAM members are encouraged to attend.

CALIFORNIA

Chapter President William Brostoff, M.D., has announced that faculty for the chapter's March 8 conference on "Caring for Pregnant Women and Newborns: Effects of Alcohol and Other Drugs," include Carol Archie, M.D., Andrea Barthwell, M.D., and Marty Jessup, R.N., M.S. Held at the Parkside Community Hospital in Riverside, the conference carries up to 6.5 hours of Category 1 CME credit.

CONNECTICUT

Connecticut members held a one-day meeting on advances in addiction medicine and policy issues in October 1995. More than 300 persons attended the meeting, chaired by Mark Kraus, M.D. Faculty included ASAM members David Lewis, M.D., and Alan Wartenberg, M.D.

Through the efforts of State Chairperson Peter Rostenberg, M.D., and Mark Kraus, M.D., the Connecticut Governor's Blue Ribbon Task Force on Substance Abuse has recommended that the state's Medicaid Managed Care Pilot Project "adheres to the principles and provides the minimum core benefits for addictions **as recommended by the American Society of Addiction Medicine (ASAM).**" The task force recommendation also incorporates a synopsis of ASAM's Public Policy statement on the Core Benefit. In other action, chapter members Dr. Henry Blansfield and Dr. Tom Payte are working with the Governor's Task Force to encourage steps that will further medicalize the treatment of narcotic dependence through medical maintenance.

FLORIDA

The Florida Chapter (FSAM) recently held its 9th Annual Conference in Orlando. Chapter President Marilyn Moss, M.D., reports that the conference was well attended and well received. (The participant who traveled the greatest distance was from Iceland!) Dr. Moss notes that new teaching approaches were used, including interactive case discussions.

GEORGIA

The Georgia Chapter (GASAM) is working with the state's Department of Human Resources to define the Patient Placement Criteria for Medicaid recipients and uninsured individuals. Chapter President Karl Gallegos, M.D., says that "We are trying to educate managed care organizations about ASAM's mission and why it is important to include ASAM certified physicians on managed care panels."

The Georgia Chapter will host ASAM's 1996 Medical-Scientific Conference in Atlanta (April 18-21). At the chapter meeting on Sunday morning, April 21, topics to be discussed include membership, managed care issues and standards of care for treatment under the Medicaid program, as well as plans for the 4th Annual Southeastern Conference on Addictions in October 1996.

ILLINOIS

The Illinois Society of Addiction Medicine (ISAM) has signed a consulting contract to provide medical consultation to the Illinois Department of Alcoholism and Substance Abuse, according to Chapter President Martin Doot, M.D. ISAM also recently negotiated an agreement under which the Illinois State Medical Society will provide administrative services to ISAM. The society is planning a training session for a March conference on addictions, as well as a workshop to precede the October 1996 ASAM Review Course in Chicago.

MAINE

Maine members are planning a state dinner meeting in the spring. Information is available from Dr. Joe Dreher of Portland, who is coordinating the event.

MICHIGAN

President Thomas Haynes, M.D., reports that throughout 1996, the chapter will conduct quarterly meetings, in addition to a special chapter meeting during the ASAM Annual Medical-Scientific Conference in Atlanta. The meeting is open to all ASAM members from Michigan.

MISSISSIPPI

Chapter President John McRae, M.D., has announced that Dr. Conway Hunter and his wife, Charlotte Hunter, will be featured speakers at the chapter's 18th Annual Caduceus Retreat in summer 1996. MSSAM also will sponsor a Recruitment Breakfast during the retreat.

Election of 1996-1997 chapter officers is scheduled for a luncheon meeting in May, held in conjunction with the annual meeting of the Mississippi State Medical Association.

NEW HAMPSHIRE
ASAM members in New Hampshire who are interested in increasing state-level activities are invited to call Dr. Alan Wartenberg (Region III Director) at 617/983-7708.

NEW YORK
Chapter President Merrill Herman, M.D., and Peter Mansky, M.D., chapter Vice President and chair of the New York Committee for Physician Health, recently arranged a meeting on medical student impairment at the Albert Einstein College of Medicine. During the meeting, attended by faculty and student representatives of four medical schools throughout New York State, the group formulated a plan for ongoing technical assistance to medical schools, as well as development of a position paper and Conference/Symposium on the issues of medical student addiction.

In other news, the chapter's March 21st business meeting at the New York Marriott Marquis features a presentation on "Addiction Medicine in Primary Care" by Marc Gourevitch, M.D., Medical Director of the Montefiore Substance Abuse Treatment Program. The chapter is planning a meeting during the ASAM Annual Medical-Scientific Conference in Atlanta. All New York members are welcome to attend.

NORTH CAROLINA
President James Frosst Alexander, M.D., has invited members of the North Carolina Chapter (NCSAM) to attend a special meeting during the ASAM Medical-Scientific Conference in Atlanta. All ASAM members from North Carolina are welcome to attend.

OHIO
Ted Hunter, M.D., has been elected President of the Ohio Chapter (OHSAM). Dr. Hunter says the chapter is seeking members to serve on state committees.

OREGON
The Oregon Chapter (ORSAM) has approved a mission statement and expanded its membership to 31, according to President Douglas L. Bovee, M.D. The next quarterly meeting is to be April 16 at 6:30 p.m. at the Sweetbriar Inn in Tualitin.

PENNSYLVANIA
Lee McCormick, M.D., has been elected President of the Pennsylvania Chapter (PASAM).

SOUTH CAROLINA
Timothy Fischer, D.O., has announced that South Carolina has been granted official chapter status. Dr. Fischer will receive the charter at the Awards Luncheon during the ASAM Medical-Scientific Conference in Atlanta. All South Carolina members are welcome to participate in this special event, as well as in a chapter meeting scheduled during the Medical-Scientific Conference.

South Carolina has already conducted several CME seminars in cooperation with the University of South Carolina Medical School campuses in Charleston and Columbia. Chapter members also are working on legislative issues.

TEXAS
Anand Mehandale, M.D., reports that the Texas Chapter conducted a very successful planning meeting in March and plans to meet again during the ASAM Medical-Scientific Conference in Atlanta.

VIRGINIA
William McConahey, M.D., reports that Virginia has received its official charter as a Chapter (VASAM). The chapter will meet next during the ASAM Medical-Scientific Conference in Atlanta, and will elect officers there. All Virginia members are welcome to attend.

VERMONT
Members in Vermont who are interested in increasing state activities are invited to call Dr. Alan Wartenberg (Region III Director) at 617/983-7708.

REGION VIII
(Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming) Regional Director Richard Tremblay, M.D., will convene a regional meeting during the ASAM Medical-Scientific Conference in Atlanta. Dr. Tremblay says he looks forward to meeting with constituents to discuss future region activities, as well as the possibility of forming new chapters.

REGION IX
(International Members) Regional Director Ray Baker, M.D., will meet with international members during the ASAM Medical-Scientific Conference in Atlanta, to encourage constituents to discuss ideas for increasing membership and the current/future role of ASAM within each country.

NIAAA HONORS KELLER: The National Institute on Alcohol Abuse and Alcoholism has established an annual lecture series in honor of Mark Keller. Enoch Gordis, M.D., NIAAA Director, said that the series will recognize Mr. Keller's "many contributions and accomplishments."

IN MEMORIAM: A long-time friend of ASAM and of the NCADD, James Royce, S.J., Ph.D., died recently in Seattle. Dr. Richard Tremblay reports that Father Royce developed and taught the nation's first standard curriculum course on alcoholism in 1950 at Seattle University; by 1973, his expanded addiction studies course became the University's Addiction Studies Program. Father Royce wrote six books on addiction studies, including a text he coauthored with LeClair Bissell, M.D., *Ethics for Addiction Professionals.* In 1965, he received the Governor's Distinguished Service Award for his efforts to combat alcoholism. Father Royce was a life member of the Board of Directors of the National Council on Alcoholism and Drug Dependence.

THE CONFERENCE DESK

NEUROSCIENCE CONFERENCE A RESOUNDING SUCCESS

Terry A. Rustin, M.D.

With the 1995 State of the Art in Addiction Medicine Conference, held in October 1995 in Chicago, ASAM set a new standard for its conferences and demonstrated that ASAM physicians are eager to integrate the latest neuroscience findings into their clinical practices. "I was very pleased, not only with the number of participants but, more importantly, how enthusiastically they responded to the basic science presentations," said Allan Graham, M.D., Course Director. "The participants gave the speakers uniformly good marks on their presentations; overall, they rated this conference higher than any past State of the Art conference," he said.

The goal of the Review Course Committee, headed by Dr. Graham, was to bring the latest in neuroscience research to addiction specialists and other physicians. Indeed, the scope and quality of presentations at the conference underscored how far the field of addiction medicine has grown beyond a loose association of doctors who treat alcoholics and addicts; rather, today's addiction specialist clearly must have expertise in medicine, psychiatry, public health and many other fields—including the neurosciences.

The course committee set a precedent by developing the curriculum in consultation with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). Course faculty were a diverse group of addiction experts, including practicing addiction medicine specialists, research scientists, psychologists and pharmacologists. "NIDA and NIAAA both were enthusiastic about the program, though perhaps initially skeptical that ASAM members would support the conference," Dr. Graham recalled. "So we were especially gratified to have an overall attendance of 330, including 170 ASAM members and 24 physicians-in-training." Whereas previous State of the Art conferences emphasized developments in all areas of addiction medicine, the 1995 conference focused specifically on the neurosciences, and including presentations ranging from clinical care to animal research to the latest findings on the molecular basis of addiction. Some of the best-known figures in neuroscience research served as faculty, includes George Koob, Ph.D., Thomas Kosten, M.D., Alan Leshner, Ph.D., George Siggins, Ph.D., Charles O'Brien, M.D., Catherine Rivier, Ph.D., and George Uhl, M.D., Ph.D.

"This conference has helped increase ASAM's credibility with NIDA and NIAAA, and with neuroscientists throughout the country," said Terry Schultz, M.D., who helped to coordinate the NIH faculty. Dr. Schultz noted that "the speakers were glad to discover that practicing physicians were interested in and conversant with their work."

Dr. Graham lauded the contributions of Drs. Terry Schultz, Lori Karan, Howard Heit, Marty Doot, Andrea Barthwell and other committee members as responsible for the success of the conference. He also singled out the contributions of liaison members John Allen, Ph.D., of NIAAA, and Dorynne Czechowicz, M.D., of NIDA. "And," he added, "we couldn't have done it without Gail Jara's help."

(Dr. Rustin, who teaches at the University of Texas School of Medicine, Houston, was a member of the planning committee for the 1995 State of the Art Conference.

The following representative abstracts suggest the scope and focus of the conference presentations.

Neurohormonal Responses to Alcohol: Catherine Rivier, Ph.D. The hypothalamic-pituitary-adrenal (HPA) axis plays a crucial role in the maintenance of homeostasis. Hormones of this axis, such as corticotrophin releasing factor (CRF), proopiomelanocortin (POMC) and the adrenal corticosteroids, exert profound influences on endocrine, metabolic, cardiovascular, behavioral and immune parameters. As alcohol represents a homeostatic threat ("stress"), it is not surprising that it alters the activity of the HPA axis. This results not only in acute changes in the parameters mentioned above, but also profoundly alters the subsequent ability of various circuitries (neuroendocrine or otherwise) to respond appropriately to stress. These altered responses may have relevance for the increased incidence of abnormal immune responses found in adult alcoholics and in children born to alcoholic mothers.

The Alcohol Withdrawal Kindling Phenomenon: Howard C. Becker, Ph.D. It has been hypothesized that the progressive intensification of the alcohol withdrawal syndrome following repeated episodes of alcohol intoxication may represent the manifestations of a "kindling" mechanism. Animal studies support the kindling hypothesis of alcohol withdrawal and provide a model with which to study potential mechanisms underlying the phenomenon.

Naltrexone: Modulating Alcohol Self-Administration: Stephanie O'Malley, Ph.D. Naltrexone is a pure competitive opioid antagonist that binds to opioid receptors but does not stimulate them. Alcohol is known to stimulate endogenous opioid release. By blocking the opioid receptors, naltrexone is hypothesized to attenuate the reinforcing effects of alcohol and alcohol-induced craving. Improved outcomes with naltrexone can potentially include abstinence or reduced drinking.

PROGRAM FOR ASAM'S 1996 MED-SCI CONFERENCE

Chairman Marc Galanter, M.D., and the members of the Conference Program Committee invite all ASAM members and nonmember physicians, nurses, psychologists, counselors, students and other health care professionals to attend ASAM's 27th Annual Medical-Scientific Conference, April 18-21, at the Atlanta Mariott Marquis Hotel. Highlights of the program include:

Thursday, April 18, 1996

Ruth Fox Course for Physicians. Course Director Alan Wartenberg, M.D., and Co-Director Lynn Hankes, M.D., have planned a full agenda for this traditional opening day of the conference.

ASAM Computer and Online Course. Stuart Gitlow, M.D., M.P.H., has organized basic and advanced courses in response to strong interest expressed by ASAM members for information on how to use electronic information to meet the particular needs of physicians, such as medical references, practice management, communications and education.

Friday, April 19, 1996

R. Brinkley Smithers Distinguished Scientist Lecture. Charles S. Lieber, M.D., Director of the Alcohol Research and Treatment Center and the GI/Liver Program at the Bronx VA Medical Center, will deliver the lecture. Dr. Lieber also is Professor of Medicine and Pathology at the Mount Sinai School of Medicine, NY.

Symposium 1: The Scientific Basis of Alcohol Policy. Organized by Enoch Gordis, M.D., Director of NIAAA, this session will afford an understanding of the research that serves as a basis of public policy related to use and availability of alcohol.

Symposium 2: Liability and Efficacy from Long-Term Use of Benzodiazepines: Documentation and Interpretation. Norman Miller, M.D., will review research data that allow the practitioner to evaluate the clinical liability and efficacy of long-term use of benzodiazepines.

Symposium 3: Medical Utility and Toxicity of Smoked Marijuana. John P. Morgan, M.D., will lead a discussion of the potential medical uses and toxicity of marijuana, as well as the political arguments and forces aligned for and against proposals for therapeutic use.

Symposium 4: The Impact of Managed Care on Chemical Dependency Treatment. James A. Halikas, M.D., has organized a session to bring together medical leaders to discuss the impact of managed care on the treatment of addictive disorders, and the utility of the ASAM Patient Placement Criteria as a treatment determinant.

Symposium 4A: Marijuana and the Brain: Current Research and Clinical Implications for the Practitioner. Dr. Peter Rogers and colleagues will present state-of-the-art knowledge of the effects of marijuana on the brain, marijuana's uses as medication and the proposed "medicalizing" of marijuana.

Saturday, April 20, 1996

Symposium 5: A Report from the National Institute on Drug Abuse. Dorynne Czechowicz, M.D., has organized a group of experts to present the findings of NIDA-sponsored research programs, as well as the Institute's education and treatment improvement initiatives.

Symposium 6: Alcohol Teratogenesis. Organizers Sidney Schnoll, M.D., Ph.D., and Enoch Gordis, M.D., will lead a panel of researchers in presenting the latest findings on the epidemiology of fetal alcohol syndrome and its relation to other major birth defects.

Symposium 7: Matching Patients to Treatment. David Gastfriend, M.D., will lead a panel of experts in reviewing current research into patient-treatment matching, focusing on questions such as: Are there optimal treatments, for whom, in what settings, and at what price?

Symposium 8: Markers of Drinking. Charles S. Lieber, M.D., has organized an expert review of the markers of short- and long-term drinking, including the effects of gender, age and liver disease, and the application of markers to early detection and prevention of relapse.

ASAM Awards Luncheon. U.S. Senator George McGovern (retired) will describe his daughter's long, ultimately fatal struggle with alcoholism and what he would urge every physician to do to prevent, intervene with or treat a patient suffering from addictive disease. Award recipients will be John B. Griffin, Jr., M.D. and Jack Henningfield, M.D. The Young Investigator Award will be presented to Robert Anthenelli, M.D.

Sunday, April 21, 1966

Symposium 9: Genetic and Other Risk Factors in Addiction: From Bench to Bedside. Mark Gold, M.D., and Elaine Johnson, Ph.D., focus on community prevention, as well as protective and risk factors that can be modified to reduce drug experimentation.

Symposium 10: Violence, Alcohol and Drugs: Neuropharmacological, Economic-Compulsive and Systemic Dimensions. Alfonso Paredes, M.D., and colleagues will review experimental data on the neuropharmacological, economic-compulsive and social system determinants of human violent behavior associated with the use of alcohol and drugs.

For conference registration, hotel and travel information, contact the ASAM Meetings Department, at 301/656-3920, or Fax 301/656-3815.

RUTH FOX FUND / ENDOWMENT NEWS

Ruth Fox
(1895-1989)

Dear Colleague:

The Ruth Fox Memorial Endowment Fund ended 1995 with a total of $1,692,746 in pledges. We thank you, our donors, for your commitment and generosity. Our goal is to reach $2 million by the end of 1996. We hope that you will help in this endeavor. Join your colleagues by making a pledge/contribution, or by increasing your current pledge/bequest. Pledges can be paid over a five-year period. All contributions to ASAM are completely tax-deductible since the Society is a 501(c)(3) organization.

We especially wish to thank George W. Nash, M.D., Tucson, AZ, a long-time member of ASAM, for naming the Endowment Fund as beneficiary of a $125,000 Charitable Remainder Unitrust, in addition to his previous generous contributions. ASAM will always be grateful to Dr. Nash.

Special thanks also to R. Jeffrey Goldsmith, M.D., Cincinnati, OH, ASAM Board Member from Region IV, for naming the Endowment Fund as beneficiary of a $25,000 insurance policy. His commitment and support are greatly appreciated.

The Yasuda Bank and Trust Company (USA), New York City, made a 1996 contribution to the Endowment, bringing its total contributions over the years to $5,500. We are very grateful to the bank's officers for their ongoing support and for helping secure the Society's future and the future of addiction medicine.

REMINDER of the special program to be presented by Paul E. Dow, J.D., on "Estate Planning for Physicians and How to Protect Your Pension Plan," Thursday, April 18, 1996, 7:00 to 8:30 p.m., during the Society's 27th Annual Medical-Scientific Conference in Atlanta. If you plan to attend, please check this session on the conference program/registration form when you return it. Everyone is invited.

The Ruth Fox Memorial Endowment Fund Reception (by invitation only) is scheduled for Friday, April 19, 1996, at the Conference. All donors will receive an invitation.

Please write to us for a free pamphlet, "Giving Through Retirement Plans." It will help you in your estate planning.

If you would like to discuss various ways you can help support the Endowment Fund, or would like to make a pledge, contribution or bequest, please contact Ms. Claire Osman, ASAM, 12 West 21st Street, New York, NY 10010. Telephone 212/206-6770 or Fax 212/627-9540.

Max A. Schneider, M.D.
Chair, Endowment Fund

Jasper G. Chen See, M.D.
Chair Emeritus, Endowment Fund

Claire Osman
Director of Development

TOTAL PLEDGES: $1,703,146
(as of January 26, 1996)

New Donors, Additional Pledges and Contributions, October 13, 1995 through January 26, 1996

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DON'T FORGET TO RENEW YOUR 1996 ASAM MEMBERSHIP!

We don't want to lose you! If you haven't renewed your ASAM membership for 1996, please do so today. We want to continue your membership services without any interruption. Remember — committee members, committee chairs, and chapter leaders are required to renew their memberships in order to maintain their posts throughout 1996. To renew, simply call Theresa McAuliffe at the ASAM Membership Department (301/656-3920, extension 108).

ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 30 PH 359 October 1995

Diagnostic Criteria for Alcohol Abuse and Dependence

Diagnosis is the process of identifying and labeling specific conditions such as alcohol abuse or dependence (1). Diagnostic criteria for alcohol abuse and dependence reflect the consensus of researchers as to precisely which patterns of behavior or physiological characteristics constitute symptoms of these conditions (1). Diagnostic criteria allow clinicians to plan treatment and monitor treatment progress; make communication possible between clinicians and researchers; enable public health planners to ensure the availability of treatment facilities; help health care insurers to decide whether treatment will be reimbursed; and allow patients access to medical insurance coverage (1–3).

Diagnostic criteria for alcohol abuse and dependence have evolved over time. As new data become available, researchers revise the criteria to improve their reliability, validity, and precision (4,5). This *Alcohol Alert* traces the evolution of diagnostic criteria for alcohol abuse and dependence through the current standards of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM–IV) (6). For comparison, the criteria found in the World Health Organization's *International Classification of Diseases, Tenth Revision* (ICD–10) also are reviewed briefly, although these are not often used in the United States (7).

Alcohol Alert, *a publication of the National Institute on Alcohol Abuse and Alcoholism, provides timely information on alcohol research and treatment to health professionals and other interested people. This issue is the thirtieth in the series.*

Diagnostic criteria are evaluated in light of new data and revised to improve their utility.

Evolution of Diagnostic Criteria

Early Criteria

At least 39 diagnostic systems had been identified before 1940 (2). In 1941 Jellinek first published what is considered a groundbreaking theory of subtypes of what was, until 1980, termed alcoholism (2,8). Jellinek associated these subtypes with different degrees of physical, psychological, social, and occupational impairment (2,9).

Formulations of diagnostic criteria continued with the American Psychiatric Association's publication of the *Diagnostic and Statistical Manual of Mental Disorders, First Edition* (DSM–I), and *Second Edition* (DSM–II) (10,11). Alcoholism was categorized in both editions as a subset of personality disorders, homosexuality, and neuroses (2,12).

The need to base diagnostic criteria on research was recognized in the 1970's.

In response to perceived deficiencies in DSM–I and DSM–II, the Feighner criteria were developed in the 1970's to establish a research base for the diagnostic criteria of alcoholism (5,13). These criteria were the first to be based on research rather than on subjective judgment and clinical experience alone (5). Though designed for use in clinical practice, they were primarily developed to stimulate continued research for the development of even more useful diagnostic criteria (5). Several years later, Edwards and Gross focused solely on alcohol dependence (8). They considered essential elements of dependence to be a narrowing of the drinking repertoire, drink-seeking behavior, tolerance, withdrawal, drinking to relieve or avoid withdrawal symptoms, subjective awareness of the compulsion to drink, and a return to drinking after a period of abstinence (8).

A Commentary by NIAAA Director Enoch Gordis, M.D. ***3***

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • National Institutes of Health

The DSM Criteria

The categories of alcohol abuse and alcohol dependence replaced the term "alcoholism" in DSM–III.

Researchers and clinicians in the United States usually rely on the DSM diagnostic criteria. The evolution of diagnostic criteria for behavioral disorders involving alcohol reached a turning point in 1980 with the publication of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (14). In DSM–III, for the first time, the term "alcoholism" was dropped in favor of two distinct categories labeled "alcohol abuse" and "alcohol dependence" (1,2,12,15). In a further break from the past, DSM–III included alcohol abuse and dependence in the category "substance use disorders" rather than as subsets of personality disorders (1,2,12).

The DSM was revised again in 1987 (DSM–III–R) (16). In DSM–III–R, the category of dependence was expanded to include some criteria that in DSM–III were considered symptoms of abuse. For example, the DSM–III–R described dependence as including both physiological symptoms, such as tolerance and withdrawal, and behavioral symptoms, such as impaired control over drinking (17). In DSM–III–R, abuse became a residual category for diagnosing those who never met the criteria for dependence, but who drank despite alcohol-related physical, social, psychological, or occupational problems, or who drank in dangerous situations, such as in conjunction with driving (17). According to Babor, this conceptualization allowed the clinician to classify meaningful aspects of a patient's behavior even when that behavior was not clearly associated with dependence (18).

Diagnostic criteria for alcohol abuse and dependence have been refined with each revision of the DSM.

The DSM was revised again in 1994 and was published as the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM–IV) (6). The section on substance-related disorders was revised in a coordinated effort involving a working group of researchers and clinicians as well as a multitude of advisers representing the fields of psychiatry, psychology, and the addictions (2). The latest edition of the DSM represents the culmination of their years of reviewing the literature; analyzing data sets, such as those collected during the Epidemiologic Catchment Area Study; conducting field trials of two potential versions of DSM–IV; communicating the results of these processes; and reaching consensus on the criteria to be included in the new edition (2,19).

DSM–IV, like its predecessors, includes nonoverlapping criteria for dependence and abuse. However, in a departure from earlier editions, DSM–IV provides for the subtyping of dependence based on the presence or absence of tolerance and withdrawal (6). The criteria for abuse in DSM–IV were expanded to include drinking despite recurrent social, interpersonal, and legal problems as a result of alcohol use (2,4). In addition, DSM–IV highlights the fact that symptoms of certain disorders, such as anxiety or depression, may be related to an individual's use of alcohol or other drugs (2).

The ICD Criteria

While the American psychiatric community was formulating its editions of diagnostic criteria for mental disorders, the World Health Organization was developing diagnostic criteria for the purpose of compiling statistics on all causes of death and illness, including those related to alcohol abuse or dependence, worldwide (1,4,20). These criteria are published as the *International Classification of Diseases* (ICD). The first ICD classification of substance-related problems, published in 1967 in ICD–8 (21), classified what was then called alcoholism with personality disorders and neuroses, as had DSM–I and DSM–II. In ICD–8, alcoholism was a separate category that included episodic excessive drinking, habitual excessive drinking, and alcohol addiction that was characterized by the compulsion to drink and by withdrawal symptoms when drinking was stopped (1).

Although ICD–9 (22,23) included separate criteria for alcohol abuse and dependence, this revision defined them similarly in terms of signs and symptoms (1). According to Babor, an important assumption in ICD–9 was that alcohol use in the absence of dependence "merits a separate category by virtue of its detrimental effects on health" (1, p. 87).

The category of alcohol dependence was central to the current revision, ICD–10 (1,2,7). Alcohol dependence is defined in this classification in a way that is similar to the DSM. The diagnosis focuses on an interrelated cluster of psychological symptoms, such as craving; physiological signs, such as tolerance and withdrawal; and behavioral indicators, such as the use of alcohol to relieve withdrawal discomfort (1). However, in a departure from the DSM, rather than include the category "alcohol abuse," ICD–10 includes the concept of "harmful use." This category was created so that health problems related to alcohol and other drug use would not be underreported (1). Harmful use implies alcohol use that causes either physical or mental damage in the absence of dependence (1).

The ICD is concerned with health problems associated with alcohol abuse and dependence.

Moving Toward Agreement Between Diagnostic Criteria

The DSM diagnostic criteria for psychiatric disorders are the criteria primarily used in the United States. The ICD is an international diagnostic and classification system for all causes of death and disability, including psychiatric disorders (4). Earlier editions of these two major diagnostic criteria dealing with alcohol abuse and dependence were criticized for being too dissimilar (2). Therefore, the DSM–IV and the ICD–10 were revised in a coordinated effort among researchers worldwide to develop criteria that were as consistent with one another as possible (1,2).

Although some differences between the two major diagnostic criteria still exist, they have been revised by consensus as to how alcohol abuse and dependence are best characterized for clinical purposes (18). Clinicians, international health agencies, and researchers are now better able to categorize people with alcohol dependence, abuse, and harmful use to plan treatment, collect statistical data, and communicate research results (18).

The latest revisions of the DSM and the ICD facilitate treatment planning, data collection, and research.

Diagnostic Criteria—A Commentary by NIAAA Director Enoch Gordis, M.D.

The research community has long found standardized diagnostic criteria useful. Such criteria provide agreement as to the constellation of symptoms that indicate the alcohol dependence syndrome and allow researchers all over the world to communicate clearly as to what kinds of disorders are being studied.

Standardized diagnostic criteria are equally important and useful to clinicians. In the alcohol field, there have been many different ways by which clinical staff might arrive at a diagnosis—sometimes differing among staff within the same program. Although the use of standard diagnostic criteria may seem somewhat burdensome, it provides many benefits: more efficient assessment and placement, more consistency in diagnoses between and within programs, enhanced ability to measure the effectiveness of a program, and provision of services to people who most need them. As we move more and more into a managed health care arena, third-party payors are requiring more standardized reporting of illnesses; they want to know what conditions they are paying for and that these conditions are the same from program to program. The standardized diagnostic criteria presented in this *Alert* are based on the newest research, have been developed based on field trials and extensive reviews of the literature, and are continually revised to reflect new findings. Although clinical judgment will always play a role in diagnosing any illness, alcohol treatment programs that use standardized diagnostic criteria will be in the best position to select appropriate treatment and to justify their selection to third-party payors.

ACKNOWLEDGMENT: The National Institute on Alcohol Abuse and Alcoholism wishes to acknowledge the valuable contributions of Marc A. Schuckit, M.D., Professor of Psychiatry, Veterans Affairs Medical Center, San Diego, California, to the development of this *Alcohol Alert*.

Table 1. DSM–III–R, DSM–IV, and ICD–10 Diagnostic Criteria for Alcohol Dependence *

	DSM–III–R	DSM–IV	ICD–10
SYMPTOMS	A. At least three of the following:	A. A maladaptive pattern of alcohol use, leading to clinically significant impairment or distress as manifested by three or more of the following occurring at any time in the same 12-month period:	A. Three or more of the following have been experienced or exhibited at some time during the previous year:
TOLERANCE	(1) Marked tolerance—need for markedly increased amounts of alcohol (i.e., at least 50 percent increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount of alcohol	(1) Need for markedly increased amounts of alcohol to achieve intoxication or desired effect; or markedly diminished effect with continued use of the same amount of alcohol	(1) Evidence of tolerance, such that increased doses are required in order to achieve effects originally produced by lower doses
WITHDRAWAL	(2) Characteristic withdrawal symptoms for alcohol (3) Alcohol often taken to relieve or avoid withdrawal symptoms	(2) The characteristic withdrawal syndrome for alcohol; or alcohol (or a closely related substance) is taken to relieve or avoid withdrawal symptoms	(2) A physiological withdrawal state when drinking has ceased or been reduced as evidenced by: the characteristic alcohol withdrawal syndrome, or use of alcohol (or a closely related substance) to relieve or avoid withdrawal symptoms
IMPAIRED CONTROL	(4) Persistent desire or one or more unsuccessful efforts to cut down or control drinking (5) Drinking in larger amounts or over a longer period than the person intended	(3) Persistent desire or one or more unsuccessful efforts to cut down or control drinking (4) Drinking in larger amounts or over a longer period than the person intended	(3) Difficulties in controlling drinking in terms of onset, termination, or levels of use
NEGLECT OF ACTIVITIES	(6) Important social, occupational, or recreational activities given up or reduced because of drinking	(5) Important social, occupational, or recreational activities given up or reduced because of drinking	(4) Progressive neglect of alternative pleasures or interests in favor of drinking; or
TIME SPENT DRINKING	(7) A great deal of time spent in activities necessary to obtain alcohol, to drink, or to recover from its effects	(6) A great deal of time spent in activities necessary to obtain alcohol, to drink, or to recover from its effects	A great deal of time spent in activit necessary to obtain alcohol, to drink, or to recover from its effects
INABILITY TO FULFILL ROLES	(8) Frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home; or	None	None
HAZARDOUS USE	When drinking is physically hazardous	None	None
DRINKING DESPITE PROBLEMS	(9) Continued drinking despite knowledge of having a persistent or recurring social, psychological, or physical problem that is caused or exacerbated by alcohol use	(7) Continued drinking despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused or exacerbated by alcohol use	(5) Continued drinking despite clear evidence of overtly harmful physical or psychological consequences
COMPULSIVE USE	None	None	(6) A strong desire or sense of compulsion to drink
DURATION CRITERION	B. Some symptoms of the disturbance have persisted for at least one month or have occurred repeatedly over a longer period of time	B. No duration criterion separately specified. However, three or more dependence criteria must be met within the same year and must occur repeatedly as specified by duration qualifiers associated with criteria (e.g., "often," "persistent," "continued")	B. No duration criterion separately specified. However, three or more dependence criteria must be met during the previous year.
CRITERION FOR SUBTYPING DEPENDENCE	None	With physiological dependence: Evidence of tolerance or withdrawal (i.e., any of items A(1) or A(2) above are present) Without physiological dependence: No evidence of tolerance or withdrawal (i.e., none of items A(1) or A(2) above are present)	None

*The DSM–III–R, DSM–IV, and ICD–10 refer to substance dependence. These criteria have been adapted in this *Alcohol Alert* to focus solely on alcohol.

Table 2. DSM–III–R, DSM–IV, and ICD–10 Diagnostic Criteria for Alcohol Abuse/Harmful Use of Alcohol*

DSM–III–R Alcohol Abuse

A. A maladaptive pattern of alcohol use indicated by at least one of the following:

(1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of alcohol

(2) drinking in situations in which use is physically hazardous

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.

C. Never met the criteria for alcohol dependence.

DSM–IV Alcohol Abuse

A. A maladaptive pattern of alcohol use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

(1) recurrent drinking resulting in a failure to fulfill major role obligations at work, school, or home

(2) recurrent drinking in situations in which it is physically hazardous

(3) recurrent alcohol-related legal problems

(4) continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol

B. The symptoms have never met the criteria for alcohol dependence.

ICD–10 Harmful Use of Alcohol

A. A pattern of alcohol use that is causing damage to health. The damage may be physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

B. No concurrent diagnosis of the alcohol dependence syndrome.

*The DSM–III–R, DSM–IV, and ICD–10 refer to substance abuse and harmful use. These criteria have been adapted in this *Alcohol Alert* to focus solely on alcohol.

References

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