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ABSTRACT

This document is one of seven publications contained in a series of materials for physicians on recognizing, intervening with, and treating adolescent alcoholism. The materials in this unit of study offer guidelines to help physicians make responsible and informed decisions about their roles with adolescent patients. Materials are presented which can help physicians to: (1) identify levels of prevention regarding use and abuse of alcohol and other substances; (2) describe fundamental steps which may be taken by physicians in addressing teenage alcoholism at each level of prevention; (3) demonstrate an understanding of the terms host, agent, and environment as they apply to the problem of teenage alcoholism; (4) discuss methods of prevention in terms of agents, hosts, and environment, given the level of prevention to be undertaken; (5) conceptualize the role to be taken personally in relationship to adolescent patients, given each level of participation; (6) clarify personal preventive activities in terms of the specific roles of advocate, educator, counselor, community change agent, and early case finder; (7) prepare a personal prevention program which identifies appropriate persons and agencies with whom to cooperate; and (8) demonstrate a thorough knowledge of local and regional consultative and referral sources for treatment of adolescents with chemical abuse problems. (NB)

Adolescent Alcoholism: Recognizing, Intervening, and Treating

(The titles and materials listed below are contained in this series.)

	Available Materials		
	Written	Audio	Video
1. Adolescents and Substance Abuse: An Overview	*	*	
2. The Physician's Role in Prevention	*	*	
3. Recognition and Diagnosis	*		*
4. Intervention with the Dependent Adolescent	*		*
5. The Physician's Role in Referral and Treatment	*		*
6. Alcohol and Other Chemicals	*		
Faculty Guide (regarding medical education, residency training, and continuing medical education)			*

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Adolescent Alcoholism: Recognizing, Intervening, and Treating

2 The Physician's Role in Prevention

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Introduction

Adolescent use and abuse of alcohol and drugs is a major health problem. Since 1976, well over half of all high school seniors have experimented with or used alcohol, tobacco, and marijuana. Ten percent or more of the high school seniors have experimented with or used cocaine. While one gets tired of hearing alarmists talking about national crises, substance use and abuse by teenagers is just such a crisis. Only through concerted preventive efforts will this crisis be abated. Physicians, by the very nature of their profession, are in a position to play a key role in preventing alcohol and substance abuse.

Goal

The goal of this unit of study is to explore and present guidelines for physicians in order that they can make informed and responsible decisions about their roles and functions vis-a-vis adolescent patients. It emphasizes the opportunities physicians have with adolescents — a relationship of continuity often extending from the prenatal period to and beyond adolescence. This unit of study conceptualizes the physician at the hub of the interactions regarding relationships with adolescents and with other persons who exert a vital and significant influence on the optimal growth and development of young people. The physician is viewed as a collaborator with persons and agencies in an effort to prevent adolescent problems related to chemical use and abuse.

Objectives

Upon completion of this unit of study, you will be able to:

1. *Identify levels of prevention regarding use and abuse of alcohol and other substances.*
2. *Describe fundamental steps which may be taken by physicians in addressing teenage alcoholism at each level of prevention.*
3. *Demonstrate an understanding of the terms agent, host, and environment as they apply to the problem of teenage alcoholism.*
4. *Discuss methods of prevention in terms of agent, host, and environment, given the level of prevention to be undertaken.*
5. *Conceptualize the role to be taken personally in relationship to adolescent patients, given each level of participation.*
6. *Clarify personal preventive activities in terms of the specific roles of advocate, educator, counselor, community change agent, and early case finder.*
7. *Prepare a personal prevention program which identifies appropriate persons and agencies with whom you might cooperate.*
8. *Demonstrate a thorough knowledge of local and regional consultative and referral sources for treatment of adolescents with chemical abuse problems.*

Overview

There is ample evidence that problems associated with adolescent use and abuse of chemicals* is a major public health problem. It is estimated that there are 3.3 million 14-17-year-old persons who are problem drinkers.[1] A survey in 1984 conducted for the National Institute of Drug Abuse revealed trends in use of five chemicals by high school seniors (Table 2-1) and is worth careful study.

Table 2-1. Trends in Use of Five Chemicals by High School Seniors[2]

TRENDS IN LIFETIME PREVALENCE OF DRUGS AMONG HIGH SCHOOL SENIORS (PERCENT EVER USED)

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984
Marijuana/ Hashish	47.3	52.8	56.4	59.2	60.4	60.3	59.5	58.7	57.0	54.9
Cocaine	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1
Alcohol	90.4	91.9	92.5	93.1	93.0	93.2	92.6	92.8	92.6	92.6
Cigarettes	73.6	75.4	75.7	75.3	74.0	71.0	71.0	70.1	70.6	69.7

TRENDS IN 30-DAY PREVALENCE OF DRUGS AMONG HIGH SCHOOL SENIORS (PERCENT WHO USED IN LAST 30 DAYS)

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984
Marijuana/ Hashish	27.1	32.2	35.4	37.1	36.5	33.7	31.6	28.5	27.0	25.2
Cocaine	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.2
Alcohol	68.2	68.3	71.2	72.1	71.8	72.0	70.7	69.7	69.4	67.2
Cigarettes	36.7	38.8	38.4	36.7	34.4	30.5	29.4	30.0	30.0	29.3

TRENDS IN 30-DAY PREVALENCE OF DAILY USE OF DRUGS AMONG HIGH SCHOOL SENIORS (PERCENT WHO USED DAILY IN LAST 30 DAYS)

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984
Marijuana/ Hashish	6.0	8.2	9.1	10.7	10.3	9.1	7.0	6.3	5.5	5.0
Cocaine	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.2	0.2	0.2
Alcohol	5.7	5.6	6.1	5.7	6.9	6.0	6.0	5.7	5.5	4.8
Cigarettes	26.9	28.8	28.8	27.5	25.4	21.3	20.3	21.1	21.2	18.7

Data regarding traffic fatalities provide gruesome statistics. In 1982, 9,263 teenagers died in alcohol-related automobile accidents.[3] Fortunately, there has been a decline of 14% from 1980 to 1984.[4] Several forces have been influential in this salutary reduction. These include Mothers Against Drunk Driving (MADD) and Students Against Drunk Driving (SADD) both of which are manifestations of an attitude which no longer tolerates driving while intoxicated and its terrible toll. Additionally, actions by state and federal governments to set the age for the legal purchase of alcohol at age 21 undoubtedly have been a deterrent to traffic fatalities related to driving while intoxicated.[4]

Teenage suicide has increased alarmingly in the past five years. How many of these deaths are associated with chemical use and abuse is not known, but it is undoubtedly a direct factor (chemical overdose) in some, or associated with chemical intoxication in others.

Further statistics need not be quoted here as they may be found in other units of study in this series and elsewhere. The key purpose of this overview is not to shock, but rather to make one aware that the problem of teenage alcoholism and substance abuse is one which must be addressed through prevention. Prevention, of course, starts with personal attitudes, beliefs, and actions, and spreads to patients, both directly and indirectly. This unit of study explores many of the potential roles physicians can take in the prevention of alcohol and chemical abuse.

Physician Self-Assessment

Physicians should assess periodically their own use of chemicals using means such as the CAGE questions. Continuing education courses are recommended for enhancing knowledge, skills, and attitudes in this area.

There are several means to assist you in self-assessment of your use of chemicals. Self-inventory scales may be altered from "you" to "I" (e.g., CAGE questions).[5]

- Have I ever felt I should Cut down on my drinking?
- Have I ever been Annoyed by others criticizing my drinking?
- Have I ever felt Guilty about my drinking?
- Do I take an "Eye opener" in the morning to help me settle down?

The National Council on Alcoholism and the Georgia Disabled Doctors Committee have self-administered checklists.[6] Another source of feedback might be to talk with a trusted colleague who sees you on social occasions

*chemical—is defined hereafter as any agent which by its use can produce pleasure or relieve pain.

and ask him about his observations about your chemical use and possible significant changes in such use. The physician who may already be in trouble with use of chemicals may not be in the best position to identify a young person with a similar problem or be effective in making an intervention. One person's denial complements the other's. Finally, remarks of your spouse or children may motivate a thorough, thoughtful, honest self-assessment.

The offerings for continuing medical education for the physician are never-ending, and many journals have sections devoted to self-instruction. How frequently these refer to chemical dependency (CD*) and how many physicians apportion some of their time to professional self-improvement in this area is a matter of conjecture. However, undergraduate and graduate medical educators are devoting more time and attention to preventive medicine—health hazard appraisal, accentuating "wellness," engaging in more effective patient education, etc. Often this includes instruction about chemical use/abuse and is a manifestation of more than lip service given to prevention.

**chemical dependency — hereafter referred to as* CD.

Levels of Prevention

Public health constructs regarding contagious diseases can be adapted to problems related to adolescent chemical abuse; these include agent, host, and environment.

Public health constructs initially used to explain contagious diseases can be adapted to issues related to prevention of adolescent chemical use/abuse. Figure 2-1, Table 2-2, and Figure 2-2 depict how this is possible.

Some or all of the persons and institutions represented in Figure 2-2 affect adolescents' attitudes and behavior about the use of chemicals. Influences are not static as adolescents grow in age and maturity (e.g., earlier on formative influences come from the family; later on peer attitudes and actions usually exert more effects). Additionally each one of these agents may be figuratively weighted. For example, the church may be a "+2" and the school a "–1." The important things to remember in using the schema of Figure 2-2 is that (1) situations do change over a period of time, and (2) each influential factor may have a positive or a negative weight, which also may be altered over time. The value of this conceptual schema is that it can be used by the physician to make a comprehensive assessment of his adolescent patient's progress, or lack of it, on the road to maturation.

Figure 2-1. Interaction of Host, Environment, and Agent

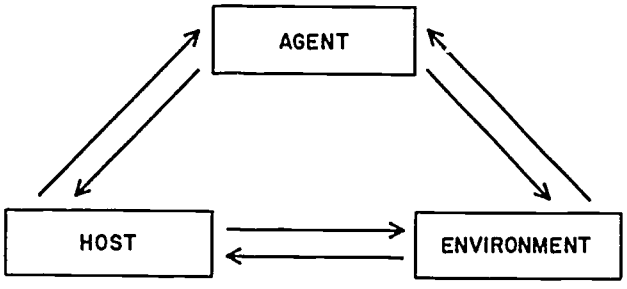
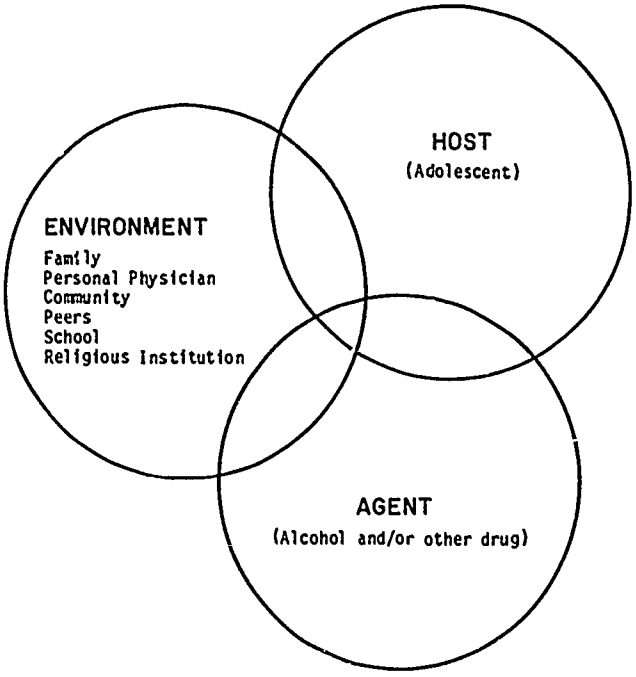


Table 2-2. Levels of Prevention in Relation to Public Health Constructs

Level of Prevention	Host	Interaction
Primary	The adolescent population at risk by reason of exposure to alcohol and/or other chemicals	1. Educate the host 2. Influence the environment in a positive manner
Secondary	The high-risk adolescent population at risk to develop CD problems due to genetic vulnerability, inadequate family nurturing, socio-economic conditions, ethnicity, etc.	1. Early identification 2. Monitor 3. Educate 4. Support
Tertiary	The adolescent population which has already developed morbidity because of CD (3.3 million problem drinkers; 19% of 14-17 year olds who are or should be in treatment)	1. Remove the host from access to the agent 2. Alter the environment 3. Strengthen the host's resistance

Figure 2-2. Host's Interaction with Agent and Environment



Primary Prevention

The Agent

Although legal access for the adolescent to the agent (chemical) is prohibited, the adolescent can obtain the agent easily. Thus mediative efforts are directed at the environment — people and institutions.

Most adolescents will tell you that alcohol and other chemicals can be obtained easily. "I can get anything I want" is probably not an empty boast, at least judging by the poly-drug abuse encountered in treatment facilities. Sedative-hypnotics, psychostimulants (cocaine, amphetamines), opiod drugs, inhalants, and hallucinogens (LSD, PCP) are readily available for adolescent experimenters/users/dependents.

What measures can be exerted to control or preclude the nonsanctioned use of the Agent(s)? For the adolescent, access to the purchase and possession of all of these agents is prohibited, yet this does not deter the adolescent having access to them.

We must therefore direct our efforts to those people and institutions in the adolescents' Environment such that they can be assisted in achieving optimal development. The adolescent is our concern, but in this unit of study we are directing attention to those who can have a significant relationship with young people, and particularly to the physician (refer to the diagram of these environmental persons and institutions — Figure 2-2).

The Host

The Host is the population at risk for chemical use and abuse — adolescents. Some of this age group are nonusers of chemicals; some may have experimented and gone no further; others may be moving beyond experimentation to more regular or heavy use (Table 2-1).

Adolescence is, or should be, a time to mature and to move from childhood to early adulthood. It requires that the young person master the tasks required in this transitional period. These include:

1. Physiological growth with establishment of gender identity and of comfort with the male or female body image
2. Individuation to establish personal identity
3. Development of wholesome peer relationships
4. Separation from parents and family
5. Development of the intellect
6. Raising concerns and questions about the spiritual
7. Consideration of career choice
8. Learning to drive an automobile
9. Learning impulse control

These developmental tasks are arduous and demand optimal physical, psychological, social, and spiritual efforts. These transitional changes undoubtedly act as stressors to the adolescent during these years. The use of chemicals does little or nothing to help the young person to adapt successfully to change. Actually, the misuse/abuse of chemicals can distort or delay the achievement of developmental milestones for the adolescent. Thus, in treatment programs we occasionally see an adolescent with a chronological age of 18 but with an emotional or intellectual age of 12. For example, retarded development occurs with heavy use of marijuana and is accompanied by the "amotivational syndrome" — a passive, lethargic, apathetic attitude and behavior in facing and achieving transitional demands for optimal growth.[7]

The Environment

The role and functions of the physician are these: (1) advocacy (speaks for), (2) educative (provides information), (3) counselor (invests time), (4) early case finder (acts expeditiously), and (5) community change agent (finds solutions).

Physician

Ideal opportunities present themselves over a period of several years for the physician to serve as the adolescent's friend, confidant, advocate, and teacher. A mutual relationship of trust requires proper nurturing. It is difficult at best, if not impossible, to see an adolescent initially at the request of his parents. A not uncommon situation such as this occurs: "Doctor, I want you to give Jack a good talking to. His father and I are pretty sure he is smoking pot." So Jack comes to see the doctor under duress, certain that his parents and the doctor are in alliance against him. The doctor is just another authority figure, and right now Jack is rebelling against all who are in authority. An adversarial situation is set up.

Physicians should make optimal use of an ongoing relationship with youngsters. Anticipatory guidance can be conveyed to the parents of the young child focusing on normal growth and development. The boundaries of normality of growth and development need to be accentuated so that the parents, and later on the young person himself, will not become unduly concerned about perceived deviations from normal (e.g., in the young female the onset of menarche from 10-15 years). Information about good health practices should be conveyed — proper diet, adequate sleep, explanation of burgeoning sexuality with the development of secondary sex characteristics, and exercise. And, there should be early and continuing alertness to chemical experimentation and use.

Rhetorical questions for you as a physician are in order. Do you feel competent and comfortable talking about use of chemicals? Could you offer authentic information to an adolescent about the metabolism of alcohol and its effects on "target organs" (liver, GI, CNS, endocrine, cardiovasular system). If an adolescent said, "What's wrong with smoking a couple of joints a day?" could you provide factual, objective information? Sometimes, such questions are a genuine desire to know the facts about chemicals; other times the adolescent may challenge the validity of your information.

Serving as a confidant/counselor of an adolescent implies a respect for each person's trust in the confidentiality of the information acquired by the physician. This may pose some problems when, for instance, the adolescent says, "You aren't going to tell my folks, are you?" If the physician believes that the adolescent's chemical use is a danger to himself or others (e.g., admitted driving while intoxicated with friends), confidentiality must be breached. If, however, the physician determines that experimentation is the case without more constant use or actual dependency, he may use his knowledge and authority to describe the potential dangers of continued experimentation and offer some viable alternatives such as selecting new friends who do not need to use chemicals to have a good time or engaging in activities where drug use is proscribed (competitive athletics, both for girls and boys).

The physician may from time to time serve as the advocate for his young patients. For instance, overly concerned parents may need to be told that "one joint doesn't make a junkie" and that some experimentation is normal. He may further suggest that the adolescent and parents meet with him to discuss experimentation and its potential dangers. It may be incumbent, on occasion, for the physician to serve as an advocate for the youth with the school, community, or religious personnel before some of these people judge too harshly or condemn some acting out behavior. In addition, the physician may want to direct his young patients to support groups in the area, contacting a sponsor for Alateen for example.

There are behavioral, emotional, and physical clues which should concern the alert physician and cause him to consider the possibility that chemical use or abuse should be included in his assessment as an early case finder. Often one of the earliest signs of adolescent dysfunction is interpersonal difficulties with family members or with school personnel (teacher, guidance counselor, coach, administrator). For example, the school guidance counselor may call the physician to suggest that an adolescent come in for a physical examination because of declining classroom performance. Or the principal may make the same request because of increased absenteeism from school due to reported illness. Not complying with these types of requests and performing a brief physical examination may miss an opportunity to engage in an exploratory interview in an objective, nonaccusatory, and empathetic manner.

Part of this diagnostic investigation may well include chemical use history. For instance:

- "Many young people use chemicals and I would like to ask you about your own use."
- "Do you feel that you need caffeine to give you a lift, or get you started?"
- "Do your friends or parents ever say they believe you drink too much coke, etc.?"

Incrementally and inclusively, proceed from the least threatening chemical uses to those which may produce harmful effects; that is, alcohol and illicit drugs. Consumption is important data, but equally essential is information about the feelings of others, about the adolescent's use, and the adolescent's own assessment and feelings about such use. The physician should also ask about his patient's perception of school activities and productivity.

The physical examination for early detection of chemical use before the young person goes beyond experimentation is not often very helpful and usually yields less data than that which can be acquired in a thorough psychosocial assessment. Occasionally, the initial use of a chemical may be associated with intoxication or overdose. This may occur in the uninitiated youth and may at times result in a tragic outcome. If a critical incident does occur, it should serve as an opportunity for intervention counseling or referral, as indicated, after the emergency care is provided.

The use of hallucinogens may give rise to bizarre, irrational actions which may result in injury to self or others. However, most young people do not ordinarily initiate chemical experimentation with such drugs. Alcohol and marijuana are the most frequently used chemicals initially.

So called suicidal "gestures" may be associated with chemical use. But again, these probably do not occur with chemical experimentation. The point to be stressed is that these signs and symptoms are not to be dismissed casually. Gestures provide the opportunity for the physician to make a meticulous etiological search and to either initiate education and counseling or to seek help via referral.

Regarding assessment, a thorough nutritional history for the young person is in order. Adolescents' eating habits are often a cause of concern for their parents. Certain chemical use (more often, dependency) may cause improper attention to a healthy diet. Amphetamines and cocaine often produce a feeling of satiety. Alcohol provides "empty calories" and is a quick source of energy, but it provides inadequate nutritional content. Drug screen evaluations [e.g., the blood alcohol concentration (BAC)], are more helpful in assessing chemical dependency rather than experimentation. Consequently, only occasionally do they assist the physician in early detection. A more useful technique is use of self-inventory scales; for example, the Adolescent Alcohol Involvement Scale.[8] It assesses the young person's use of alcohol; it does not identify the alcohol-dependent adolescent. The CAGE questions[5] may be helpful in early identification and are easy to administer. They can be used in evaluating other chemical use by replacing "drinking" with a different chemical. For example, "Have you ever felt guilty about your drinking?" Substitute "use of marijuana." Or, "Have you ever been annoyed about someone criticizing your drinking?" Substitute "your use of cigarettes." Another self-inventory measurement is the Michigan Alcoholism Screening Test (MAST)[9]; however, it is not helpful in early identification for the adolescent.

The mental status exam can be of aid in early detection, particularly in assessing the affective state of the adolescent. This is useful for determining how the patient relates to the physician and estimating any apparent disparity regarding chronological or emotional ages.

Early detection depends primarily on obtaining a thorough history. In primary and secondary intervention, selective use of self-inventory scales may reveal more relevant information than either the physical examination, laboratory, or special studies.

Adolescent Peers

A teenager may well join a peer group with a system of values quite different from that of his or her parents. The physician may have opportunities to become more aware of the situation and might carefully explore it.

The old aphorisms "birds of a feather flock together" and "a man is known by the company he keeps" are relevant in evaluating the quality of the adolescent's peer group. One clue to chemical abuse occurs when an adolescent changes peer group affiliations. The physician may be informed by parents of an adolescent patient that he or she now has a different group of friends, a group of

young people whose values and life style may be disparate from theirs (i.e., the parents' own). They have usually expressed their disapproval of the behavior of their adolescent's choice of companions and may even have attempted to put restraints on those relationships. On the other hand, the adolescent may inform the doctor of parental disapproval, "My folks don't like my friends." The physician should use his empathic skills, listen carefully to the complaints, and acquire additional data.

- "Why do you suppose your folks feel that way?"
- "How do you feel about your parents' opinion of your friends?"
- "What attracted you to this group?"
- "What kinds of friends do your parents approve of?"

The data acquired may assist in making an objective evaluation of a not uncommon parent-adolescent conflict, being certain not to align yourself with either party. It may be helpful to indicate that parents want the best for their children. An invitation can be offered to ask the adolescent to come in with his folks to talk about this situation.

A physician in a small community is likely to interact fairly extensively with the young people in the community through school athletic contests, community and church activities, when making home visits, etc. Many "extracurricular" pieces of data can be extracted from such interactions which may be valuable in assessing the quality of peer group affiliation of adolescent patients. Adolescents, like adults, usually are attracted to people with similar values and activities. Unfortunately, young people may not exercise sound judgement in selecting "friends." They may be attracted to others because of their differences, their alienation from the "straight" people, their daring and risk-taking behavior, impulsivity, or rebelliousness. Attraction may be due to appearances of excitement or because the values presented are alien to their parents. Often the opportunity to express autonomy is sought for whatever reason. Often these alignments are transient and lose their attraction with time. This evaluation can be helpful when conveyed to the concerned parents of adolescents. Thus, they should be encouraged to be as tolerant and as positive as possible. A more active intervention by all concerned is mandated when it is determined accurately that the choice of companions of the adolescent is those who are engaged in destructive or maladaptive illicit activities. We do have to protect our young people from harm.

The School

School policies on chemical abuse and programs for health promotion vary greatly. If a responsible individual at a school contacts the physician for assistance with a student, the physician should try to clarify the problem with the individual prior to an evaluation with the adolescent.

The adolescent customarily spends nearly 40 hours a week in school. The educational setting has the potential of affecting the adolescent's attitudes and behavior regarding the use of chemicals. This influence occurs usually by a statement of policy by the school administrators in regard to conduct of students (truancy, dress code, use of automobiles during school hours, etc.). These policies emanate from the school board and reflect community norms.

Most school systems have some sort of instruction in health matters. This may be episodic and limited in scope; that is, an annual lecture by a physician, a school nurse, or a physical education teacher about the three M's — menarche, menstruation, and masturbation. Some schools are addressing health, physical growth, and development issues by adopting comprehensive, kindergarten-through-high school health instructional programs which provide increments of information commensurate with young persons' physical and emotional development and desire to learn. The content and format of such programs may be a reflection of community concerns and values. Ideally, such instruction should accent positive attitudes about optimal physical and emotional growth.

Persons who interact with adolescents and who, if perceptive and sensitive, are in a position to detect early indications of adolescent dysfunction are probably more influential than are policy statements. Such a person may be a favorite classroom teacher in whom the adolescent confides, the school guidance counselor, a secretary, a school nurse, a custodian, a coach of an athletic team, band director, etc. Adolescents' evaluations of "school" are often harsh and judgemental, but it is rare not to find someone to whom the young person can relate.

School systems have state-mandated drivers' training for adolescents. What may be a missing ingredient in such instruction is the caveat about the dangers of driving

while intoxicated with chemicals. Learning when to merge on a freeway, making proper use of directional lights, obeying speed limits, etc., can be dulled by chemical abuse. This needs to be stated emphatically.

The interaction between the school, the adolescent, and the physician may occur at two levels. One may be a request from a school official for direct assistance. This may occur as an urgent demand for intervention in a case of intoxication or overdose by an adolescent. The physician needs to know how to treat this emergency or seek assistance via referral. Another scenario might go like this: Dr. FP receives a phone call, "Doctor, I am the guidance counselor at the high school. I am concerned about one of your patients, Susie Q, and would like to send her to you for a complete physical examination." Dr. FP might respond, "Sure, send her up and I'll check her over." This is less than appropriate; preferably he would ask, "What is the problem? Why now? What do you believe is wrong? What exactly do you expect me to do?" The point being Dr. FP needs a good deal more data before he can respond effectively to such a request.

Occasionally, the physician may get a request or invitation to act as a preventive agent via the physician's role as professional. The physician may receive a request to talk to an adolescent group about the physiological/psychological effects of the abuse of chemicals. If the physician complies with such an invitation, he needs to know what has preceded and what will follow his talk (i.e., is this a "one shot" instructional effort or part of a more inclusive program). He must realize, if he does not already know, that adolescents are quite sophisticated about chemicals and that he may be challenged about the information he imparts. It should be valid information that can authenticated if he wishes to establish credibility.

The physician may on occasion be asked to be advisor to the school board and administrators regarding programs and policies relating to problems associated with students. As a physician, you should consider it your responsibility to accept such requests.

Religious Institutions

Religious institutions offer considerable potential for working with young people in the prevention of chemical use and abuse.

On the average, 120 million persons, adults and youth, participate in one or more weekly religious services.[10] A majority of young people have some relationship with a religious institution, be it a church, temple, or synagogue. The duration and strength of this affiliation may be quite variable during infancy, childhood, adolescence, and early adulthood. It is subject to vicissitudes and is altered by the individual's age, relationship to the nuclear and extended family, religious instruction, influence of peer group affiliation, and the relevance of instruction. Adolescence is a time of idealism coupled with cynicism and disillusionment regarding what the young people perceive to be the hypocrisy of adults. Religious instruction can serve to capture and channel the romantic idealism of young people into constructive means of moving toward a healthy maturity. Religious confirmations often symbolize rites of passage; in the Jewish tradition, this symbolizes a transition to adult status. Achievement of adulthood implies responsible decisions and actions.

The use of alcohol in certain rituals of various religions accents the day with remembrance and celebration. Inebriation is proscribed in these circumstances. For example, on selected Jewish holy days the use of wine is permitted for ritual and celebratory purposes, and some Christians celebrate the Eucharist with the use of wine. Many religions and related organizations are facing up to the awareness that their members may well have problems because of chemical dependency. Church membership or denominational proclamation does not preclude the existence of these problems among its members; yes, even among its clergy. Two examples may be cited to illustrate the increasing sensitivity and awareness of this concern. The *Episcopalian* (November, 1985) defined the Episcopal Church's program of prevention and intervention for CD. Selected statements are germane:

- Chemical dependency is a disease, not a moral problem or a sign of weakness of character.
- This disease can be diagnosed and treated at an early stage with an excellent chance of recovery.
- The disease is not only treatable; it is preventable.
- Families and friends do not need to sit by hopelessly and watch addicted loved ones destroy themselves. They can prevent and intervene to help their loved ones enjoy life once again.

A recent news release reported the awareness of the chemical use among the membership in the Southern Baptist denomination, one which has held a strong traditional proscription about drinking. Reporting on a

survey of the Southern Baptist membership, the article stated that 50 percent of the membership drink alcohol, and of those who do 16 percent become alcoholics (in the general population 10 percent of those who drink are alcoholics). Further, the survey revealed that 25 percent of the church's active young people had used alcohol once during the 12 months immediately preceding the survey. It also stated that (1) Southern Baptists have tended to ignore their alcohol and drug problems because of their historic public opposition to alcohol, and (2) churches have not provided adequate abuse prevention and education for their members. Rather, the standard approach has been to tell members drinking is bad so don't do it (Charleston, South Carolina, *Sunday News & Courier,* February 2, 1986).

What then is the relevance of all such data to the physician who will be caring for adolescents who have a religious affiliation? This information may be helpful to the physician as he collaborates with the religious institutions in his community to act in a preventive, early intervention role in problems associated with chemical use. Answers to these questions may be helpful in working for a responsible attitude toward chemical use.

1. What, if any, is the religious affiliation of this adolescent?
2. Does this particular religious institution have a stated policy with regard to use of chemicals (abstinence, responsible use, ritualistic use)?
3. Does this adolescent's family attempt to follow stated policy? Does the adolescent?
4. What are the family's feelings about these guidelines?

Finally, some physicians may serve as youth group leaders, may be church school teachers, or may be invited to talk to the young people about alcohol and drug abuse. These opportunities should not be bypassed.

The Community

The physician should be familiar with community norms regarding chemical use. For example, socioeconomic factors may play a role in the development of chemical dependency. On the other hand, there also needs to be a cognizance of the resources available from such groups as MADD.

The physician should possess a data base about the community in which he practices. Is this a healthy environment in which to bring up children? Specifically, in regard to chemical use and abuse, what are the prevailing attitudes and behaviors? What is acceptable? What is not? Who are the persons and what are the avenues by which community norms are articulated (e.g., are kids' parties supervised?) Has this community expressed its concern and provided information regarding adolescent chemical use via the media and such programs such as MADD, SADD, and "Chemical People?" Have the concerns and help been channeled constructively at the community level? For example, one program in an affluent southwestern Michigan community was mobilized by parents who were concerned enough. The program was called Community In Action (CIA). This acronym did not escape adolescent notice and remarks. Interested parents were organized into several functional committees to explore prevalence of use, prevention, education, intervention, and treatment resources. Of course, the significance and sustained activity of such community action and its impact on the problem needs evaluation. However, even if such efforts prove to be short-lived, they may succeed in arousing the awareness that one potential threat to optimal adolescent growth comes from steady use and dependence on chemicals.

When the opportunity presents itself, the physician should inquire from both adolescents and their parents about their perceptions of the value of these types of community endeavors. He may wish to initiate or to serve in such a group. Because of the respect the physician enjoys in the community, he can be an effective spokesman for responsible use of chemicals. Better yet, he may offer viable alternatives to chemical use (e.g., recreational opportunities without chemicals, speaking out against parties in adolescents' homes without parental supervision, etc.). He may know the stores where alcoholic beverages are sold illegally and may even know the proprietors. He may hear from parents or adolescents about violations of the legal restrictions on the sale of alcohol to minors and may choose to act aggressively to direct action against illicit sales.

Broken homes, child abuse, parental chemical abuse — these are known to the physician. Such conditions are directly or indirectly associated with CD. Unemployment, foreclosure on mortgages with loss of homes, and poverty are socioeconomic conditions beyond the physician's control, but they may well be associated with CD. Certain ethnic/cultural groups have a higher than normal prevalence of alcoholism (e.g., American In-

dians). Once again this should be part of the physician's comprehensive data base.

Secondary Prevention

Secondary prevention emphasizes the high-risk adolescent and what can be done to assist the individual.

Secondary prevention focuses particularly on the high-risk Host; that is, those young persons who are at increased risk for the development of chemical dependency. In discussing the reasons for this heightened vulnerability, particular emphasis will be given to the physician's opportunities and obligations to these adolescents. Keep in mind that what has been discussed previously under Primary Prevention regarding the Agent is still true in Secondary Prevention.

The Host: Genetic Vulnerability

Optimal environmental conditions occur if concerned persons, agencies, and institutions in the Host's milieu collaborate to channel their endeavors to accomplish the following goals:

- identifying the high-risk Host,
- exercising vigilance and surveillance of the Host's growth and development,
- providing sound educational programs over and beyond those provided for the adolescents not at high risk, and
- demonstrating the courage and ability to serve as Agents of early intervention at the earliest signs of dysfunction due to suspected chemical abuse.

Knowledge of the family history is critical in identifying high-risk individuals. Research findings support a genetic component of alcoholism.

The identification of the adolescents at increased vulnerability for potential chemical dependency involves a thorough knowledge of the family history. No one has or should have better access to these data than the family's primary physician. Good patient/family records which include up-to-date genograms serve as reminders of the genetic vulnerability of adolescent patients.

Those physicians who have followed families across more than one generation realize that there is often a genetic contribution in some disease that puts the offspring of diseased parents at high risk for developing that particular disease. Physicians are aware of this in the trans-generational perpetuation of alcoholism, as are others, particularly the children of alcoholics (7 million young people and 21 million adults[11]) and other health professionals who work with alcoholics.

Donald Goodwin, M.D., a psychiatric investigator, did some pioneer research in the Scandinavian countries during the 1970's in an attempt to substantiate the existence of a genetic contribution for transference of alcoholism from parent to child. He chose the Scandinavian countries because of their homogenous population and because of their thorough public health records. Goodwin's investigations revealed significant findings to support hypotheses regarding a genetic contribution to the transmission of alcoholism.[12]

Specifically, Goodwin was able to check the records of children of alcoholic parents who were adopted at birth and raised by foster parents who were not alcoholics. The incidence of heavy drinking in the adopted male children did not differ significantly from nonadopted male children of alcoholic parents raised by their own biological parents. A following study involving identical twins revealed that if one twin was alcoholic there was a high degree of concordance that the other twin would be an alcoholic, even though the twins were separated by geographical distance. These findings were not replicated in fraternal twins.

Goodwin raised the rhetorical question, "If alcoholism is inherited, what is inherited?" He answered the question by stating that the inherited factor was a "lack of tolerance" to the Agent, alcohol.

Researchers are trying to find a genetic marker that will allow the identification of individuals who have a predisposition to alcoholism.

Recent investigators have focused efforts on finding a genetic marker that, if discovered, could assist those who work in the preventive aspects of alcoholism. Such a marker would allow the identification of those children of alcoholic parents who have a markedly increased vulnerability for the development of the disease.

Henri Begleiter, M.D., has studied the sons of alcoholic parents before they reach the teens and has found

that they display an unusual response to a photic stimulus with a particular and unusual P. 300 brain wave. The response to this same stimulus by chronic alcoholic men is strikingly similar.[13]

Mark Schukit, M.D., also has conducted comprehensive studies attempting to identify a genetic marker. His investigations were done on young adult male sons of alcoholic parents and a matched cohort for age and socioeconomic status who were not offspring of alcoholic parents. Subjects were thoroughly investigated for psychological status, body sway (static ataxia), metabolism of acetaldehyde, and their reactions to raising the blood alcohol concentration (BAC). The only differences in these studies were that the BAC rose slower for the same doses of alcohol in the children of alcoholics and, when both groups reached the same BAC, the children of alcoholics reported a subjective feeling of being less intoxicated than the children of nonalcoholics.[14]

Given these types of findings, it may not be too far into the future that a genetic marker can be identified, and those who work with alcoholics, including the physician, can be more specific in the identification of the high-risk population and more focused in their preventive efforts. It may also dispel the belief that alcoholism is a moral defect.

The Family

Family attitudes toward alcohol use, either too restrictive or too permissive, may be a factor in the development of alcoholism.

Previously discussed attitudes and behaviors about the use of alcohol in the home identify two parental attitudes which may lead to alcohol abuse. One is the family in which any use of alcohol is rigidly proscribed and equated with a mortal sin. The other is the family in which no guidelines are given either by precept or, more importantly, by example, and the parents are seemingly unconcerned about the influence they exert on their children. In other words, the first parental attitude is proscriptive; the second permissive. Some workers in the field recommend a middle ground, that of prescription which sets limits on the kind, place, and amount of use and encourages a responsible use.[15]

Not all persons who later have problems with their use of alcohol are offspring of alcoholic parents. The physician who has followed longitudinally families in which one or both parents have been alcoholic has observed that some children are scarred emotionally and physically (see the Fetal Alcohol Syndrome literature) while other siblings are less affected, being normal or above normal in their development and achievements. This facet is now being investigated so that the vicissitudes and influences which result in a healthy outcome can be identified. This is an enormous task because of the many variables which can affect the eventual outcome (e.g., age of child, sex of alcoholic parent; pattern of drinking by parent, episodic or steady; other family supports, etc.).[16]

Margaret Cork in her little book, *The Forgotten Children,* anecdotally and poignantly documents the destructive impact of parental alcoholism on the children. This book is well worth reading as it so vividly captures the effect of parental drinking in all its pervasive effects.[17]

The physician benefits from familiarity with family-system theory. Certain familial patterns in the use of alcohol have been shown to affect the individual child.

A knowledge of family dynamics in health and disease and family systems theory is useful to the physician in directing preventive endeavors. For example, Wolin and his co-workers studied the effect of parental inebriation on family rituals, which were defined as certain scheduled family activities that had a special significance (e.g., having the evening meal together, always celebrating Christmas with grandparents, etc.). Using observations of family occasions, two types of reactions were identified. The first type they called the "distinctive family" in which the observance of the ritual was not disrupted by parental drunkenness. The other type of family was defined as subsumptive — a complete inability to follow the ritual because of inebriety of one parent. The significance of this research is that there was considerably less perpetuation of alcoholism in the children of the distinctive family than in the subsumptive one.[18]

Peter Steinglass, in a thorough and scholarly fashion, investigated the alterations in the behavior of family members during wet (drinking), dry (abstinent), and transitions (moving from one to the other) stages of parental drinking and the influence on the family's ability to accomplish its tasks for growth and development. Not surprisingly it was found that these vicissitudes of parental alcoholic activities produced distortions in the normative life cycle.[19]

Community Agencies

Community agencies such as Alateen and Children of Alcoholics should be involved at the first sign of chemical abuse in high-risk individuals.

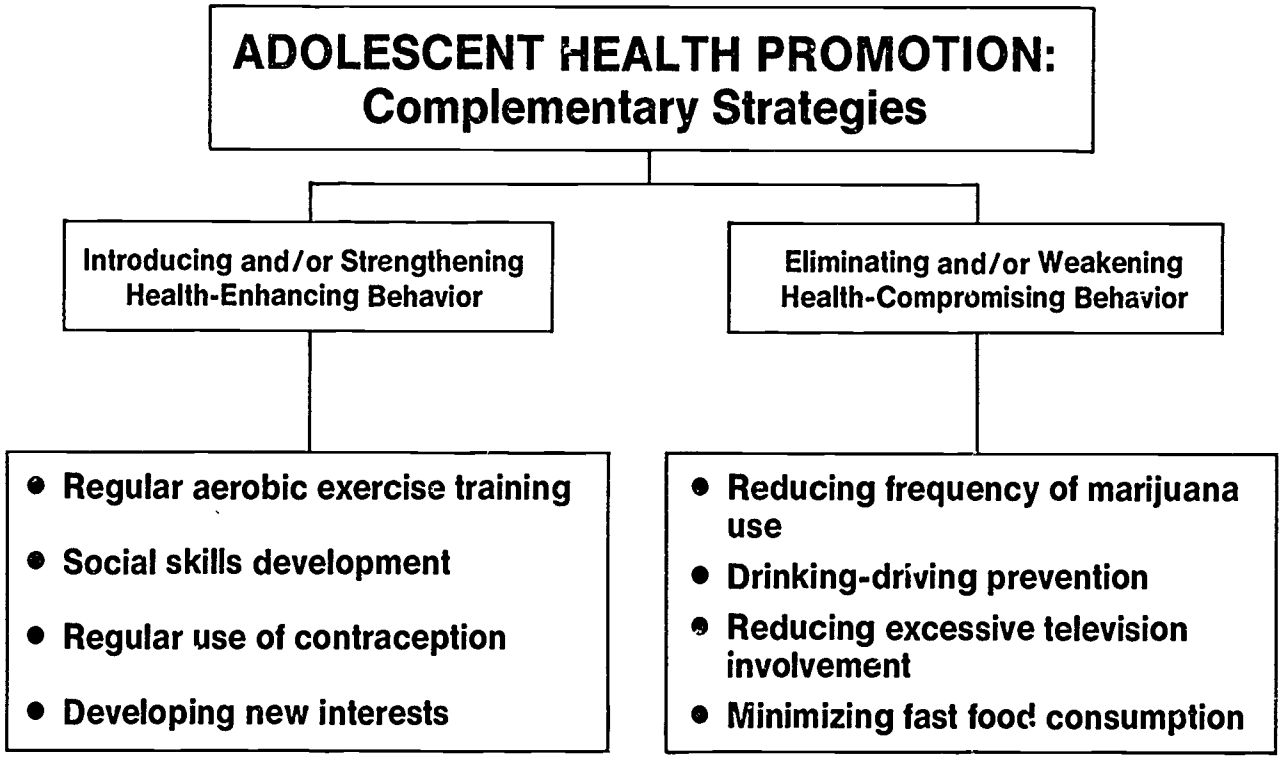
Community agencies which have proven helpful for the children of alcoholics are Alateen, an Alcoholics Anonymous constituent group, and a relatively new national coalition called Children of Alcoholics. In addition, those community people and agencies discussed under Primary Prevention need to be encouraged and directed to exert greater efforts for high-risk adolescents. They too, like the physician, must have the knowledge and courage to intervene at the earliest evidence of dysfunction which is, or is suspected of being, due to chemical abuse. A more charitable attitude and a sincere desire to help rather than early condemnation is called for. Chemical dependency is a treatable disease, and that fact should be conveyed emphatically to all — to the chemically dependent person and to all who truly care about him or her and who are interested in the prevention of these problems.

Summary

The focus of this unit of study has been on the physician and his relationships to adolescents. The premise has been advanced that the physician has a vital opportunity to serve as an important person with those other concerned persons who constitute the environment of the adolescent. It has not been the intent to dictate or to delineate the physician's responsibilities, but rather to offer some information which it is hoped will be of assistance in making informed decisions.

In summary, prevention strategies must be multifaceted. Of particular interest to the physician is the two-pronged complementary strategy of introducing and strengthening health-enhancing behaviors while at the same time eliminating and/or weakening health-compromising behaviors (see Figure 2-3). Issues of particular

Figure 2-3. Health-Enhancing Versus Health-Compromising Behaviors



From National Institute on Drug Abuse. Research Monograph Series #47. Department of Health and Human Services Publication No. (ADM) 83-1280, 1983, p. 57.

note are promotion of physical exercise training for youth, social skills development, regular use of contraception, and helping youth to develop new interests. The physician is in a key position to support, encourage, and otherwise participate in the promotion of these healthy behaviors.

Implementation alone will not eliminate drug-use problems. The second arm of the adolescent health promotion strategy includes active campaigns and ongoing task forces to work toward the elimination of negative, health-compromising behaviors. Of paramount concern is the behavior of drug and alcohol use. Particularly, the community can be rallied to reduce the frequency of marijuana use as well as promote drinking-driving prevention. Mothers Against Drunk Driving (MADD), as well as Students Against Drunk Driving (SADD), are eager to participate in community activities which are aimed at prevention of driving while drinking.

Further, some communities have become active in reducing the excessive television involvement by the teenage population. Still other communities are active in promoting good nutrition and minimizing fast-food consumption. Again, the physician is in a position to participate in as many areas as his or her time will permit, to promote health-enhancing behaviors, and to discourage health-compromising behaviors. In order for prevention measures to take effect, a broad-based, multifaceted approach is essential. Additionally, it takes time to put these strategies into effect; one should not be discouraged when, on a short-term basis, outstanding results are not evident.

Evaluation

Successful preventive activities, be they directed toward alcoholism, substance abuse, or any of the many other conditions which threaten well-being, require that the physician be knowledgeable about the Agent, the Host, and the Environment. In the case of substance abuse, becoming knowledgeable is often a simple matter of becoming aware of one's surroundings. In this exercise, you will be asked to observe, record, and share your perceptions of your surroundings as related to substance abuse and to assess how you might interact with those about you to help prevent substance abuse.

Activity 1. Get to know your Environment.

A. Spend some time assessing the prevalence of risk factors for alcoholism and substance abuse in your community. As you do this, pay close attention to such things as community social structures, adolescent peer group "norms," and societal and family structures within your community. Try to categorize those things in your community which would support or promote adolescent alcoholism and substance abuse and identify those factors which most strongly influence adolescents to use or abuse chemicals.

B. Examine your community carefully to identify those persons, groups, or activities which serve to disuade adolescents from alcohol and substance abuse and which assist in treating adolescents who have substance abuse problems. Pay special attention to those persons, groups, and activities who are successful at actively providing alternatives to use and abuse.

C. Working with the information you collect in A and B above, write a brief community profile as related to adolescent alcoholism and substance abuse. Share this with others knowledgeable about the community and revise as necessary.

Activity 2. Get to know your Hosts.

A. Do a chart review on your adolescent patients and identify those most likely to be at risk for alcoholism and substance abuse. Be sure to examine all factors which may place an adolescent at risk (biological, psychological, social). Record, for each adolescent, why you feel they are at risk.

B. Review your list of adolescent patients and determine how severe you feel the risk to each patient is.

C. Discuss with your colleagues, while maintaining confidentiality, 4 or 5 of your adolescent patients who are most at risk.

Activity 3. Develop Strategies for Prevention.

A. Given the work done in Activity 1, develop a list of possible actions you could take to:

   1. Lessen the influence of those environmental factors which promote or support adolescent alcoholism and substance abuse.
   2. Increase the impact or facilitate the efforts of persons, groups, or activities which divert students from the use of alcohol or other substances. Discuss your recommendations with colleagues and specialists in alcoholism and substance abuse.
   3. Given the work done in Activity 2, develop an approach to monitoring an active intervention with your patients at risk. Discuss your recommendations with colleagues and specialists in alcoholism and substance abuse.

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Resources for Physicians

Audio-Visual Materials

Films (16mm; color)

A Slight Drinking Problem, 1977
25 min.; rent or purchase

Availability:

Norm Southerly Productions
1709 E. 28th
Long Beach, CA 90806

Synopsis:
The troubles that befall an alcoholic are exacerbated by his wife's reactions and her attempts to deal with him. With the help of Al-Anon, she begins to deal with her own life.

Use:
Excellent for demonstrating the value of self-help groups such as Al-Anon.

Doctor, You've Been Lied To, 1978
27 min.; free loan (not available for purchase)

Availability:

Ayerst Laboratories
685 Third Ave.
New York, NY 10017

Synopsis:
Film actor Patrick O'Neal, a recovering alcoholic, offers guidelines on identifying and confronting the alcoholic patient. The format is interviews with physicians and alcoholic patients. Information on the use of disulfiram (Antabuse) is given at the end of the film.

Use:
Since Ayerst Laboratories manufactures Antabuse, this film is one of the best sources of information on prescribing this deterrent drug for recovering alcoholics.

Francesca Baby, 1976
46 min.; rent or purchase

Availability:

Walt Disney Educational Media
500 S. Buena Vista St.
Burbank, CA 91500

Synopsis:
A mother's excessive drinking causes social and emotional problems for her daughters. The mother eventually goes to Alcoholics Anonymous. Based on a book of the same title.

Use:
Although long, the film is good for demonstrating the predicament of the teen children of alcoholics and the role Alateen can play in helping them resolve their problems.

Soft Is the Heart of a Child, 1978

20 min.; rent or purchase

Availability:

Operation Cork
P.O. Box 9550
San Diego, CA

Synopsis:
Family violence, child abuse, and neglect are depicted in a believable setting. An alcoholic father convinces his wife to join him in drinking. The film illustrates such themes as the family consequences of drinking, community paralysis, women as battered spouses and drinkers, children as victims and emissaries to the community, the role of the school, and enabling.

Use:
Demonstrates the effects of alcoholism on the family. Each of the three children responds almost predictably. Highly recommended for medical students.

The Enablers, 1978
23 min.; rent or purchase

Availability:

The Johnson Institute
10700 Olson Memorial Hwy.
Minneapolis, MN 55441

Synopsis:
The well-intentioned behavior of family, friends, and a supervisor helps an alcoholic mother-wife-employee-neighbor to continue her drinking. Each person close to the woman suffers yet seems unable to break out of a self-defeating pattern of interaction; each person is shown undermining the efforts of the other to gain control over the woman's problem. First of a two-part series with *The Intervention.*

Use:
Good for demonstrating the dynamics of the chemically dependent family and the process of enabling.

The Intervention, 1978
28 min.; rent or purchase

Availability:

The Johnson Institute
10700 Olson Memorial Hwy.
Minneapolis, MN 55441

Synopsis:
Second in a series with *The Enablers,* in this film the husband joins forces with the supervisor to gather together family and friends for coercive, constructive confrontation of an alcoholic wife-mother-employee-friend. The process of setting up such a confrontation is demonstrated, including the pitfalls to successful preparation.

Use:
Excellent for supplementing *The Enablers,* for demonstrating enabling family dynamics, intervention, and teamwork. Also good for demonstrating how one can help the emissary from a troubled family to motivate a chemically dependent person to seek treatment.

The Secret Love of Sandra Blain, 1976
27 min.; rent or purchase

Availability:

Hollywood Enterprises
6060 Sunset Blvd.
Hollywood, CA 90028

Synopsis:
The first in a three-part series, *The Secret Love of Sandra Blain* is the convincing story of a middle class housewife whose hidden drinking becomes obvious to her family and friends. Denial by Sandra and her husband limits the effectiveness of therapy. Eventually the alcoholism becomes so severe that denial no longer helps Sandra deceive herself or those around her.

Use:
An excellent introduction to alcoholism and the middle class housewife. The film elucidates denial as one of the key factors in alcoholism.

The New Life of Sandra Blain, 1976
27 min.; rent or purchase

Availability:

Norm Southerly Productions
1709 E. 28th
Long Beach, CA 90806

Synopsis:
Because of Sandra's alcoholism, she is denied custody of her children. She begins to drink again. The frustration with drinking problems eventually turns Sandra back toward treatment. This film is the second in the Sandra Blain series.

Use:
Useful in pointing out that relapses often occur in alcoholism treatment, but they need not cause despair.

Lisa: The Legacy of Sandra Blain, 1979
22 min.; rent or purchase

Availability:

Aims Instructional Media
626 Justin Ave.
Glendale, CA 91201

Synopsis:
Sandra Blain's daughter, Lisa, starts down the heavy drinking road following her mother's death. Lisa cannot be convinced she has a problem. Lisa is the third part of the Sandra Blain series.

Use:
Points out the fact that children who have one or more alcoholic parent are in a high-risk group. Emphasis is on identifying "the problem" in oneself.

Video Cassettes

Alcoholics Anonymous: An Inside View, 1979
28 min.; rent as 16mm or long-term lease as video cassette

Availability:

Alcoholics Anonymous
Box 459
Grand Central Station
New York, NY 10163

Synopsis:
This video cassette takes the viewer inside a variety of AA meetings, from the smallest, intimate closed meetings to the large, open ones. It emphasizes the idea that AA is a way of life: Any time two members get together there is an AA meeting.

Use:
An excellent introduction to Alcoholics Anonymous; especially helpful for medical students prior to their visiting any AA meeting.

Identification of the Alcoholic Patient, 1978
22 min.; rent or purchase

Availability:

Department of Family Practice
University of Michigan School of Medicine
Ann Arbor, MI 48104

Synopsis:
Dr. Michael Liepman conducts a skillful interview using a student to portray a young patient in the early phase of alcoholism. Demonstrating a sensitive approach to the denial mechanism, the interviewer enables the patient to start taking an honest look at himself.

Use:
Good as an introduction to interviewing alcoholic patients as well as obtaining a drug-use history; appropriate for first or second year medical students.

Slide Program

Alcohol Use and Its Medical Consequences, 1981
(A three-part series produced by Operation Cork)

Availability:

Milner-Fenwick, Inc.
2125 Greenspring Dr.
Timonium, MD 21093
(800) 638-8652

Biochemistry, Pharmacology, and Toxicology of the Alcohols. 49 slides: $100
Alcohol and the Liver. 59 slides: $115
Hematologic Complications of Alcohol Use. 40 slides: $85

Synopsis:
This slide series presents a clear, concise overview of the biochemistry, pharmacology, toxicology, and liver pathologies as well as hematologic complications of alcohol use.

Use:
Among the best available, this accurate and beautifully illustrated series is especially useful for students in the basic sciences. Highly recommended for any level of medical education.

Other Teaching Materials/Resources

Addiction Research Foundation and Ontario Medical Association. *Diagnosis and Treatment of Alcoholism for Primary Care Physicians.* Toronto: Alcoholism and Drug Addiction Research Foundation, 1978. $1.95 each. Copies available from Marketing Services, Addiction Research Foundation, 33 Russell St., Toronto, Canada M5S 151.

American Medical Association. *Drug Abuse: A Guide for the Primary Care Physician.* Monroe, WI: American Medical Association, 1981. $17 each. Copies available from Order Department OP-323, American Medical Association, P.O. Box 821, Monroe, WI 53566.

American Medical Association, *Manual on Alcoholism.* 3rd rev. ed. Monroe, WI: American Medical Association, 1977. Copies available from Order Department OP-185, American Medical Association, P.O. Box 821, Monroe, WI 53566.

Lewis, D.C. Diagnosis and management of the alcoholic patient. *Rhode Island Medical Journal* 63:1-3, 1980. Single copies of this article are available from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852 (Order No. RPO301).

Massachusetts Department of Public Health, Division of Alcoholism. *The Office Treatment of the Alcoholic Patient,* by Mullin, C.S. Boston: Massachusetts Department of Public Health, 1978. Single copies available free from Division of Alcoholism, Massachusetts Department of Public Health, 755 Boylston St., Boston, MA 02116.

National Clearinghouse for Alcohol Information, Health Professions Education Project. *Medical Abstracts for Educators in Alcohol and Drug Abuse,* 1980. Single copies available free from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852 (Order No. RPO308).

National Clearinghouse for Alcohol Information, Health Professions Education Project. *The Primary Care Physician and the Patient with Alcoholism,* by Clark, W. D., 1980. Single copies available free from the National Clearinghouse for Alcohol Information, P.O Box 2345, Rockville, MD 20852 (Order No. RPO-305).

Vista Hall Foundation. *Drug Abuse and Alcoholism Newsletter.* Published 10 times per year; this newsletter is available free from the Vista Hill Foundation, 3420 Camino del Rio North, Suite 100, San Diego, CA 92108.

Resource Reviews. Film and Literature Evaluations.
1. Alcohol and Other Drugs, 1979-1983. 2. Youth and Families.
Wisconsin Clearinghouse, 1954. E. Washington Avenue, Madison, WI 53704. Excellent review of current literature and films. Write for catalog.

Organizations and Agencies

Addiction Research Foundation
33 Russell St.
Toronto, Canada M5S251
(807) 595-6000

The Addiction Research Foundation offers a number of educational materials for sale, including pamphlets, fact sheets, books, and audiovisual products. Two periodicals are published: *The Journal* and *Projection* (film and video review service). An *Educational Materials Catalogue* can be obtained by writing to the foundation.

Center of Alcohol Studies
Research Information and Publications Division
Rutgers University
P.O. Box 969
Piscataway, NJ 08854
(201) 932-3510

The Research Information and Publications Division of the Center of Alcohol Studies is concerned with the systemization of knowledge about human uses of alcohol. The division's specialists collect, classify, and abstract scientific literature on alcohol and alcoholism and make this organized knowledge available through the following publications and services. Prepaid orders are shipped postage free.

The Journal of Studies on Alcohol—A primary source of new information on all aspects of alcohol and alcohol problems; published monthly; $35 annual subscription. To order, write Journal of Alcohol Studies at the above address.

Other Publications—The Publications Division also publishes and distributes a variety of books, monographs, and technical and nontechnical pamphlets and reprints. A catalog of publications is available on request.

Bibliographies—A list of more than 500 bibliographies is available on request. All bibliographies are updated continually and are keyed to abstracts in the RCAS collections. Photocopies of abstracts or full-text documents are also available. A fee of $2.50 covers photocopying costs.

Information Services—The Center of Alcohol Studies Library houses major collections of books, periodicals, dissertations, and other materials pertaining to alcohol studies. Full library services are available for use in person or by mail, including interlibrary loan and photo duplication of materials. For further information or to request services, contact Research Information Staff.

National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

The National Clearinghouse for Alcohol Information is an information service of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It is a central point where information is gathered from world-wide sources and disseminated to the field. The Clearinghouse offers the following products and services:

Information Requests

Responses and Referrals—Clearinghouse staff respond to individual inquiries of a personal, professional, or technical nature. They provide referrals to other agencies when appropriate.

Literature Searches—Clearinghouse specialists perform searches of computerized files containing citations and abstracts for scientific, technical, and programmatic documents in areas such as medicine, physiology, biochemistry, public health, psychology, animal research, treatment and therapies, mental health, legislation and criminal justice, safety, sociology, prevention and education, statistics, and special population groups.

Publications

The Clearinghouse distributes, free of charge, limited numbers of alcohol-related pamphlets, books, posters, and other materials published by NIAAA. These range from audiovisual information, to program idea books, to basic question-and-answer pamphlets, to reports to Congress summarizing the current scientific knowledge on alcoholism and alcohol abuse. Order forms and lists of materials are available.

a. *Health Professions Education Project Package for Medical Educators*—This package contains a wide range of curriculum resources for the instructor in alcohol and drug abuse.

b. *Directories of Treatment Resources*—Directories of alcoholism treatment programs provide information for each of the 50 States on type of program, services, admission requirements, and accreditation.

c. *Alcohol Topics In Brief*—The Clearinghouse produces a series of fact sheets that offer concise information on subjects of high interest to the alcoholism community. Current topics include alcohol and youth, alcohol and women, health insurance coverage for alcoholism, and minimum drinking age.

d. *Selected Translations of International Alcoholism Research (STIARS)*—Important foreign language articles are translated and made available by the Clearinghouse to researchers and other interested persons. Some topics include "Alcoholism in Women," "Recent Statistical Elements Concerning the Prevalence of Alcoholism in Italy," and "Heart Defects of Children From Alcoholic Mothers."

e. *Law and Legislative Summaries (LLS)*—A series of summary publications offers information on status, provisions, and other details relating to legislation at both the State and Federal level.

Subscription Services

The Clearinghouse offers three subscription services that are aimed at keeping professionals and nonprofessionals informed about the latest developments in alcoholism and alcohol abuse prevention, treatment, and research.

NIAAA Information and Feature Service (IFS)—Emphasizing trends in alcohol-related programming and research, the Clearinghouse produces a news series that covers educational developments, policy decisions, and local programs across the Nation. The activities of NIAAA and other alcoholism organizations are also reported. There is no subscription charge for this publication, which is issued 12 to 14 times per year.

Alcohol Health and Research World—The quarterly magazine of NIAAA has proved to be a reliable resource for those who want to keep abreast of current developments in the alcohol field. Regular features of the magazine include survey articles, new programmatic approaches, research findings, and in-depth reports on all aspects of alcohol, as well as book reviews.

The annual rate for *Alcohol Health and Research World* is $8.50 for domestic subscriptions ($10.65 foreign). To receive a 1-year subscription to *World* send your remittance to:

Superintendent of Documents
U.S. Government Printing Office
Department 35
Washington, DC 20402

Alcohol Awareness Service—This free service provides periodic, continuing notification of recent technical and scientific books, journal articles, conference proceedings, and programmatic materials. Alcohol Awareness Service registration forms are available from the Clearinghouse.

All requests for information, publications, and subscriptions should be mailed to the Clearinghouse at the above address.

National Council on Alcoholism (NCA)
Publications Department
733 Third Ave.
New York, NY 10017
(212) 986-4433

NCA distributes a wide variety of publications on all aspects of alcohol use and abuse. For a full listing, write NCA for a *Catalog of Publications.*

National Clearinghouse on Drug Abuse Information (NCDAI)

NCDAI serves as a focal point within the Federal Government for the collection, dissemination, and exchange of drug abuse information. It offers the following products and services:

Audiovisual Information

Audiovisual Loan Service—A free audiovisual loan service is operated through NCDAI. Films may be borrowed, one at a time, for a 14-day period, through interlibrary loan only. To reserve a film or other audiovisual, call (301) 443-6614. Mail interlibrary loan forms to:

NIDA Resource Center
5600 Fishers Lane
Parklawn Building, Room 10A-54
Rockville, MD 20857

Film Guides—Two publications are available: *Drug Abuse Films (1980)* and *Where the Drug Films Are: A Guide to Evaluation Services and Distributors.* This second publication provides sources of inexpensive and free loan audiovisuals from Federal, commercial, and nonprofit distributors. Single copies of each available free from:

NCDAI
P.O. Box 416
Kensington, MD 20795

Publications

NCDAI maintains an inventory of more than 300 publications that are disseminated free upon request. Materials of interest to physicians include:

Prevention/Education Materials—A wide range of topics are covered and available upon request.

Research Issue Series—A series that includes abstracts of research studies, one bibliography, and two essays on current issues of interest to the drug research community. Sample issues: *Use and Abuse of Amphetamine and Its Substitutes,* Issue 15; *A Cocaine Bibliography,* Issue 12; *Drugs and Psychology,* Issue 19.

Research Monograph Series—A series that provides critical reviews of current research problem areas and techniques, state-of-the-art conferences, integrative research reviews, and significant original research. Sample items: *Narcotic Antagonists: Naltrexone,* Monograph 9; *Review of Inhalants: Euphoria to Dysfunction,* Monograph 15; *Behavioral Tolerance: Research and Treatment and Implications,* Monograph 18; *PCP—Phencyclidine Abuse: An Appraisal,* Monograph 21.

SAODAP Monograph Series—A series of monographs originally developed by the Special Action Office for Drug Abuse Prevention and now available through NCDAI. These monographs are on a variety of research topics, including epidemiological studies and techniques for providing drug abuse treatment services. Sample item: *Outpatient Methadone Treatment Manual.*

Special Bibliographies—A series of annotated bibliographies for the professional or technical audience on current topics of interest. Sample item: *Methadone and Pregnancy.*

Technical Papers—A new series of scientific reviews for the professional or technical audience on drug abuse research issues. Sample item: *CNS Depressants.*

Special Reports—Sample items: *Acute Drug Reactions in a Hospital Emergency Room; The Aging Process and Psychoactive Drug Use; Marijuana and Health 1980; Medical Treatment for Complication of Polydrug Use; NIDA Research on Drug Abuse: Publications for the Scientific and Professional Community; Sedative-Hypnotic Drugs: Risks and Benefits; Consequences of Alcohol and Marijuana Use.*

Single copies of these and many other publications of use to the health professions educator may be obtained, free of charge, subject to availability. For complete monthly publication listing and order form, write to:

NCDAI
P.O. Box 416
Kensington, MD 20795

Medical Monographs (in print or in process)—This series provides medical personnel with current, practical information on drug abuse problems and treatment methodologies. May be used as a resource for practicing physicians or as a teaching aid.

Volume I, No. 4, October 1977:
Emergency Treatment of the Drug-Abusing Patient for Treatment Staff Physicians

Volume I, No. 5, January 1978:
Pharmacological and Toxicological Perspectives of Commonly Abused Drugs

Volume I, No. 6, August 1978:
Diagnosis of Drug and Alcohol Abusers

Volume I, No. 7, June 1979:
Primary Physician Guide to Drug Abuse Treatment

Volume II, No. 1, July 1980:
Frequently Prescribed and Abused Drugs: Their Indications, Efficacy and Rational Prescribing

Volume II, No. 2, August 1980:
Treatment of the Drug and Alcohol Abuser

Single copies are available free from:

National Drug Abuse Center
Materials Distribution Facility
12112 Nebel St.
Box 5352
Rockville, MD 20852

Library

The Resource Center maintains an 800-volume back collection, subscribes to more than 400 scientific technical journals and newsletters, and maintains a collection of journal articles on microfiche. For additional information and loan policies, write to:

NIDA Resource Center
5600 Fishers Lane
Parklawn Building, Room 10A-54
Rockville, MD 20857

Mailing Lists

NCDAI maintains mailing lists for six subject areas: epidemiology, law/policy documents, prevention/education, research papers/reports, training, treatment. For further information or to be placed on one of these lists, write to:

NCDAI
Dept. ML
5600 Fishers Lane
Parklawn Building, Room 10A-53
Rockville, MD 20857

National Institute on Alcohol Abuse and Alcoholism

National Institute on Drug Abuse

Both have excellent monographs on substance abuse issues. The following are particularly noteworthy:

1. *Treatment Services for Adolescent Substance Abusers.* DHHS Publication No. (ADM) 85-1342. Printed 1985.

   This volume describes different ways to deliver treatment and intervention services to adolescent drug abusers, including the following:
   - Making appropriate referrals
   - Doing adequate evaluation of the individual's problems and assets
   - Determining specific treatment needs
   - Individualizing treatment
   - Initiating treatment
   - Providing indicated physical health, educational, vocational, basic counseling, group therapy, and alternative activity services.

An additional factor addressed in this book is how treatment issues and methods are different for adolescents than they are for adults.

Obtain from
NIDA
5600 Fishers Lane
Rockville, MD 20857

2. Fifth Special Report to the U.S. Congress on *Alcohol and Health,* Dec. 1983. DHHS Publication No. (ADM) 84-1291. Printed 1984.

   This document provides an overview of current problems in alcoholism and alcohol abuse, including alcohol and health, epidemiology, genetics and alcoholism, psychosociological effects of alcohol, medical consequences, effects on pregnancy, social consequences, treatment, and prevention trends.

3. NIDA Research Monograph Series.

   This monograph series is very informative and helpful to the practicing physician. Single copies can be obtained by writing:
   DHHS, Public Health Service
   Alcohol, Drug Abuse and Mental Health Administration
   PHS Printing and Reproduction Management Branch
   5600 Fishers Lane
   Rockville, MD 20857

   No. 35 - *Demographic Trends and Drug Abuse, 1980-1995.*
   DHHS Publication No. (ADM) 81-1069. Printed 1981.

   No. 38 - *Drug Abuse and the American Adolescent.*
   DHHS Publication No. (ADM) 81-1166. Printed 1981.

   No. 47 - *Preventing Adolescent Drug Abuse: Intervention Strategies.*
   DHHS Publication No. (ADM) 83-1280. Printed 1983.

   No. 61 - *Cocaine Use in America: Epidemiologic and Clinical Perspective.*
   DHHS Publication No. (ADM) 85-1414. Printed 1985.

   No. 63 - *Prevention Research: Deterring Drug Abuse Among Children and Adolescents.*
   DHHS Publication No. (ADM) 85-1334. Printed 1985.

   Drugs and American High School Students, 1975-1983.
   DHHS Publication No. (ADM) 85-1374. Printed 1984.

   This volume is a must for practicing physicians. It is a compendium of information on use and abuse of all the major drugs of abuse by high school students.

Books

Loving an Alcoholic: Help and Hope for Significant Others, 1985, Jack Mumey. Chicago: Contemporary Books, 214 pp.
Excellent book for helping family members cope with alcoholism in the family.

Teen-age Alcoholism, 1976, James Haskins. NY: Hawthorn Books, 156 pp.
Examines the facts and misconceptions about alcohol and alcoholism.

Alcohol in America: Taking Action to Prevent Abuse, 1985, Steve Olson with Dean Gerstein. National Academy Press, Washington, DC.