RELATED RESEARCH

First Steps

Four books:

• Cults
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• Alcoholics Anonymous
Effects on Humans of Δ⁹-Tetrahydrocannabinol
Administered by Smoking

Marc Galanter, Richard J. Wyatt, Louis Lemberger, Herbert Weingartner, Tom R. Vaughan, Walton T. Roth

Abstract. Twelve chronic marijuana users received Δ⁹-tetrahydrocannabinol by smoking. The magnitude of their pulse increment was highly correlated with their subjective experience. Three of the 12 subjects subsequently received Δ⁹-tetrahydrocannabinol labeled with carbon-14; the time course of its concentration in plasma was highly correlated with the pulse increment. Subjective symptoms, however, appeared later and dissipated more slowly.

Numerous studies have been carried out to assess the effects of marijuana (1). In many of these studies, natural marijuana or its putative active component, Δ⁹-tetrahydrocannabinol (Δ⁹-THC), was administered by smoking. Correlations of the concentration of Δ⁹-THC in plasma with psychological and physiologic effects after administration by smoking were not, however, made.

We report here on a comparison between a 10-mg dose of synthetic Δ⁹-THC and placebo marijuana material, both administered to 12 subjects by smoking. The subjective description of effects was qualitatively similar but quantitatively different for the two states. The magnitude of the syndrome as described subjectively by individuals receiving a live Δ⁹-THC correlated very highly with their respective pulse increments.

In order to assess the time course of these variables, we administered to three of the subjects the same dose of
Marihuana and Social Behavior

A Controlled Study

Mare Galanter, MD, New York; Richard Stilwell, MD; Richard J. Wyatt, MD;
Tom B. Vaughton, MD, Herbert Weingartner, PhD, Washington, DC; Fran Lucien Nurnberg, MA, New York

 Experienced marihuana users, solicited to join three twenmember sensory groups, smoked marihuana, a placebo, and no drug during 12 experimental group meetings, arranged in a balanced order. Questionnaire responses previously standardized on these subjects were analyzed, revealing the nature of cognitive and behavioral effects experienced. Although somatic sensory experiences and feelings of detachment were consistent in the marihuana condition, no consistent affective changes, increased insight, or increased feelings of cohesiveness were experienced.

These subject responses were at variance with those anticipated by subjects in light of their previous marihuana experiences, and were probably influenced by marihuana folklore. In this context and at this dose level, marihuana is found to function as a mild psychocholoromimetic; there is little reason to expect the drug to be effective either as an adjunct to group therapy or as an antithreatensser.

Numerous studies have indicated that the short-term effects of marihuana intoxication are at least as prominent in the realm of subjective experience and social behavior as they are in that of cognitive functioning. This project was designed to clarify effects of marihuana on interpersonal behavior, as well as the effect of social interaction on the subjective marihuana experience itself. Studies on the social effects of marihuana have adopted any one of three approaches: (1) psychometric measures have been applied to persons while smoking marihuana in relative isolation in neutral laboratory settings. (2) Some investigations have simulated a social atmosphere similar to that experienced by marihuana users during their typical smoking experiences. (3) Others have been based on retrospective questionnaire evaluations of marihuana users.

In all these cases, it is difficult to differentiate between these effects reported by subjects as influenced by the marihuana "folksore" of their subculture, and those that have a physiologic basis that is not culture-bound. This study was designed to clarify some of the questions arising from this latter issue. In order to do this, certain vectors relevant to group dynamics were examined.

We drew on Schutz's studies of group cohesiveness, Bates's and Hill's typology of individuals' verbal productions in groups, and Yalom and Leiberman's studies of behavior in encounter groups. The work of the latter three investigators was particularly useful in deriving measures to assess the social context that we chose to study, namely

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Marihuana and Social Behavior/Galanter et al
CULTS
FAITH, HEALING, AND COERCION
SECOND EDITION
MARC GALANTER
The "Moonies": A Psychological Study of Conversion and Membership in a Contemporary Religious Sect

BY MARC GALANTER, M.D., RICHARD RABKIN, M.D., JUDITH RABKIN, PH.D., AND ALEXANDER DEUTSCH, M.D.
Sociobiology and Informal Social Controls of Drinking

Findings from Two Charismatic Sects

Mark Galanter, M.D.
The "Relief Effect": A Sociobiological Model for Neurotic Distress and Large-Group Therapy

BY MARC GALANTER, M.D.

The author discusses the new discipline of sociobiology. He develops the hypothesis that relief of neurotic distress may be associated with experiencing social affiliation and presents data that demonstrate a decline in neurotic symptom intensity in individuals who joined a cohesive religious sect. Anthropological and ethological evidence for the adaptive value of this "relief effect" provides a basis for the evolution of this trait. The author proposes a corresponding model for psychotherapy in large groups.

This generation has seen considerable growth in large-group therapeutic modalities such as encounter groups, Alcoholics Anonymous, and therapeutic communities. In this paper I propose an experimental model for neurotic distress and its relationship to large-group therapy. It is based on the new discipline of sociobiology, which applies evolutionary principles to social behavior.

THE SOCIOBIOLOGICAL PARADIGM

Until the second third of this century, patterns of social behavior were not considered to be subject to evolutionary principles—largely because they were assumed to be primarily the product of experience. Darwin, however, anticipated modern ethology, the study of animal behavior, in relating behavior to biological function, and because he made this connection his descriptions of animal behavior have at times been criticized and even described as "extreme anthropomorphism" (1, p. 188), for example, when he wrote, "With what care male birds display their charms..." studying how best to exhibit their beauty." (2, p. 402). Darwin's presentation of animal behavior in terms of human attitude did, in effect, imply a biologically grounded similarity in adaptive function between the social behavior of different species. Such phenomena were later studied in depth by ethologists such as Lorenz (3), who compared them to anatomical analogues and homologues.

Ethological approaches like these led to a reformulation of evolutionary models that had previously been applied exclusively to morphology. It became apparent that the nature of much of animal social behavior was also rooted in biology and was therefore subject to its genetic and, ultimately, evolutionary impact. This perspective was termed "sociobiology" by Wilson (4) and is based on the interaction between the genetic basis of an individual's behavior traits and the effect of these traits on the adaptive capacity of relatives, that is, individuals who transmit the same genes. A central concept of sociobiology is therefore the reevaluation of personal fitness, i.e., the relative ability of an individual to assure transmission of his or her genes through reproduction (5). As reformulated, inclusive fitness (6) now adds to the individual's personal fitness his influence on the fitness of all relatives and remote kin who may carry the same genes, through the consequences of his behavior. For large population groups that have some degree of consanguinity, the mathematical models for such population genetics are called intergenic selection (7).

THE "RELIEF EFFECT"

Ideally, sociobiological studies are conducted with large populations over sufficient generations to observe the impact of a changed environment on the gene pool. Consequently, the application of sociobiological models to human behavior is methodologically difficult. Nonetheless, sociobiology may lead to significant shifts in our understanding of human psychopathology. For example, Wilson (4) pointed out that, regarding social behavior, "a trait can be said to be adaptive if it is maintained in a population by selection" (p. 23). On this basis, certain traits that are now considered to be "maladaptive individual pathology" may be reinterpreted. Actually, these traits may have evolved as adaptive aspects of genetically grounded social behavior, thereby increasing inclusive fitness.
FIGURE 1. The Charismatic Large Group as an Open System

INPUT
Dissonant beliefs and personal ties outside the group

TRANSFORMATION
Conversion through social and cognitive change

MONITORING
Leadership structure and social proximity

OUTPUT
Adherence to group norms

FEEDBACK
Meaning attributed to observed output

BOUNDARY CONTROL
Distinctive character and social cohesiveness
Self-Help Large-Group Therapy for Alcoholism:
A Controlled Study
Marc Galanter, MD

An innovative approach to ambulatory alcoholism treatment is proposed, based on adapting a self-help modality to the institutional clinic setting, for more cost-effective care. It draws on the principles of social influence in large groups, and diffuses the therapist's perspectives among more advanced patients. The program thereby operates with half the usual counseling staff. In this study (n = 235), a controlled comparison of this approach was made with more conventional clinic treatment, based on small-group therapy. Retention and quit rates of the experimental patients over 1 year of care were no different from the control patients, and engagement of inpatients into ambulatory care was more effective.

Most ambulatory programs for alcoholism treatment are modeled after ones used in general psychiatric clinics; they rely primarily on professionally conducted individual and small-group therapy. Whether there are more cost-effective options, however, needs to be investigated. This paper describes a study which documented the feasibility of an alternative approach to alcoholism treatment, based on psychological influence in a self-help context, and designed to allow for decreased staffing.

The experimental treatment was designed to draw on the principles of large-group psychological observation in free-standing self-help approaches to addictive illnesses, such as Alcoholics Anonymous and the drug-free therapeutic communities, as well as certain contemporary religious sects, which we have described. Both group formats have reflected changes in addictive behavior by means which are qualitatively different from the usual hospital-based therapy. We hoped thereby to tap a paradigm for social influence different from the typical small therapy group, and drawing instead on a broader base of mutual support and leadership among patients in the clinic overall.

The specific aim of the study was then to ascertain whether this experimental approach based on a large-group self-help model could achieve patient retention and visits comparable to the typical outpatient treatment format, while using half the counseling staff. If so, this might serve as the basis for developing more cost-effective means for ambulatory alcoholism treatment. This report will begin with a description of the format of the control and experimental programs, so as to clearly define the nature of this treatment approach.

METHOD

The Clinical Setting
The Facility: This study was conducted at the Bronx Municipal Hospital Center, a general medical care facility and teaching hospital with 902 beds; its alcoholism program includes 20 beds and an ambulatory program with over 500 active patients. Because these patients are largely unemployed, with limited social stability and resources, they carry a relatively poor prognosis.

Staffing: Primary therapists in the program are social workers and paraprofessionals experienced in alcoholism treatment, supervised by attending psychiatrists. There is one social worker and one paraprofessional treating the patients in the experimental self-help treatment cohort, and two members of each of the latter disciplines treating the controls, i.e., the patients of six primary therapists, were studied. Primary therapists for the experimental program were selected from the regular clinic staff on the basis of an interest in participating in the program, but were not judged to be different from the control therapists in their overall skills. Equal numbers of patients are admitted to both the control and experimental self-help programs so that the number of admissions for therapists in the experimental program is twice that of the control program, in which therapists each carry about 50 patients in ongoing treatment. All therapists have additional responsibilities in the clinic, such as the triage evaluation of new patients.

Patient Selection: The criteria for admission to the program are the diagnosis of alcohol abuse or dependence (DSM III criteria), and the absence of drug abuse and acute disabling illness, either medical or psychiatric. All patients are assigned to primary therapists in a random fashion upon admission, in accordance with a code based on the sequence of presentation at the clinic. Changes in this sequence and transfer of patients between therapists are not permitted. This system assures a random assignment of patients to therapists and hence to the experimental and control treatment programs. The number of subjects in the study, altogether 235, is broken down as follows: (1) admissions through the outpatient route (control n = 70; experimental, n = 70); (2) admissions through...
Network Therapy for Addiction: A Model for Office Practice

Marc Galanter, M.D.

Individual therapies in office practice are often considered to have limited effectiveness in treating alcohol and drug dependence. In this article, the author describes network therapy: an approach developed to assure greater success in such treatment. It uses psychodynamic and behavioral therapy while engaging the patient in a support network composed of family members and peers. A cognitive-behavioral model of addiction, based on the role of conditioned withdrawal in relapse, is described. Related techniques for securing abstinence are then reviewed: they augment individual psychotherapy to help patients avoid relapse caused by the affective and environmental cues that precipitate drug seeking. The role of social coherence as a vehicle for engaging patients in treatment is outlined next, along with a related technique for enhancing an addicted patient's commitment to the therapy. This is done by using the patient's family and peers as a therapeutic network to join the patient at intervals in therapy sessions. The network is managed by the therapist to provide coherence and support, undermine denial, and promote compliance with treatment. The author presents applications of the network technique designed to sustain abstinence and describes means of stabilizing members' involvement. Applications of network therapy to ambulatory detoxification, dual issues, and methadone administration, relapse prevention, and contingency contracting are reviewed.

Am J Psychiatry 1993; 150:28–36

Addictive illness is a highly prevalent psychiatric disorder and a well-recognized national priority. Nonetheless, techniques for rehabilitating alcohol- and drug-dependent patients in office practice are not well established (1). Even psychiatric residency programs have only recently begun to require training for treatment of such patients, and such training often focuses primarily on problems of detoxification (2). The task of developing rehabilitation techniques is therefore important if substance dependence is to be managed within the mainstream of mental health, without routinely turning to specialized inpatient units. To this end, I shall describe a cognitive-behavioral model of addictive behavior relevant to ambulatory care and a related approach to individual therapy that draws on techniques for engaging support from family and peers.

NEED FOR A NEW PERSPECTIVE

Substance abuse treatment is a great challenge for psychiatry as any clinical issue that has emerged in recent decades. This was evident in the epidemiologic Catchment Area Study, where the lifetime prevalence of abuse and dependence across study sites was 15% for alcohol and 6% for other drugs (3). These were the disorders with the highest prevalences for men and for women across all age groups and the highest prevalences for women between ages 18 and 24 years (4). The cost of alcohol and drug problems to American society in health care, lost productivity, and law enforcement is also enormous. It is greater than that of all other mental illnesses combined ($144 versus $129 billion in 1985) (5), Furthermore, support for addiction treatment is not growing. Recognition of the severity of the substance abuse problem in the 1970s initially led to an increase in inpatient care. The availability of beds in designated units increased by 62% from 1977 to 1984, and all of this net gain was in the private sector (6). During this time, the "Minnesota model" for inpatient management (7), based on a protracted inpatient stay, became a standard of treatment for many middle-class substance abusers. A recent wave of cost containment, however, has led bed occupancy rates in nonprofit facilities to fall as low as 60% (8); the decline has been fueled by a lack of evidence for the relative advantage of inpatient over ambulatory clinic care (1). Managing addicted patients in office practice may potentially be less costly, but reports on its relative effectiveness have not been positive. Hayman (9), in an early survey of psychiatrists in practice, found that very few possessed an appreciable degree of success in treating alcoholics in office practice. No difference in outcome was found when outpatients were offered individ-
Network therapy: Decreased secondary opioid use during buprenorphine maintenance

Marc Galanter, M.D.*, Helen Dermatis, Ph.D., Linda Glickman, Ph.D., Robert Maslansky, M.D., M. Brealy Sellars, M.D., Erna Neumann, M.A., R.N.C., Claudia Rahman-Dajarric, B.A.

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Abstract

Network therapy (NT) employs family members and/or friends to support compliance with an addiction treatment carried out in office practice. This study was designed to ascertain whether NT is a useful psychosocial adjunct, relative to a control treatment, for achieving sustained illicit heroin use for patients on buprenorphine maintenance. Patients agreeing to randomization to either NT (N = 33) or medication management (MM; N = 33) were induced onto short-term buprenorphine maintenance and then tapered to zero dose. NT 23% experienced a positive outcome relative to secondary heroin use by the end of treatment. The use of NT in office practice may therefore improve the effectiveness of stimulating secondary heroin use during buprenorphine maintenance. It may also be useful in enhancing compliance with an addiction treatment regimen in other contexts. © 2004 Elsevier Inc. All rights reserved.

Keywords: Network Therapy, Buprenorphine, Heroin, Addiction treatment, Social support

I. Introduction

Network therapy (NT) is an office-based treatment for substance abuse (Galanter, 1993a, 1993b) that engages a group of a patient’s family or friends in therapy sessions along with the patient. This is carried out in addition to individual therapy, and can be combined with a referral to a Twelve-Step program. The network sessions are employed to help the patient draw on potent cohesive ties to family and friends to stabilize compliance with a treatment plan. The active ingredients of NT emerge out of a cognitive-behavioral focus. They do so by adding on a family/supportive component for augmenting the cognitive focus with the support of closely related drug-free collateralists (friends/family). Network Therapy incorporates some of the components of both Community Reinforcement (Azlin, Sisson, Meyers, & Godfrey, 1982) and Behavioral Marital Therapy (O’Farrell & Fals-Stewart, 2003), such as behavioral skills training and medication monitoring by a significant other, but may be more amenable to the treatment of patients in a private practice setting. Cognitive Behavioral Therapy differs from NT in that it focuses on the patient’s cognitive and behavioral response to coping with cues to relapse with little attention to support from others and, in so doing, approximates treatment typically administered in outpatient substance abuse settings involving a 1:1 setting of client and therapist.

Network therapy has been shown to be useful in yielding diminished drug use (Galanter, Keller, & Dermatis, 1997a; Keller and Galanter, 1999; UKATT Research Team, 2001; Copello, Oxford, Hodgson, Tober, & Barrett, 2002; Galanter, Dermatis, Keller, & Trippola, 2002; Rothenberg et al., 2002). Here we present results of a controlled study designed to ascertain whether NT can enhance compliance with addiction treatment. A specific aspect of treatment outcome was chosen for evaluation in this study, namely, the avoidance of illicit opioid abuse during buprenorphine maintenance.

Most studies to date on buprenorphine maintenance show that many subjects continue to use heroin over the course of their treatment. One multi-site study illustrated this problem in the context of managing patients in physicians’ individual offices (Fudala et al., 2002). Patients were maintained on buprenorphine for as much as a year, and urine toxicologies
Combined Alcoholics Anonymous and Professional Care for Addicted Physicians

Marc Galanter, M.D., Douglas Talbott, M.D., Karl Gallegos, M.D., and Elizabeth Rubenstein, B.A.

The authors studied 100 impaired physicians who were inappropriately treated in a program that combined professionally directed psychotherapeutic treatment and peer-led self-help. An average of 13.4 months after admission they all reported being abstinent and rated Alcoholics Anonymous (AA) as more important to their recovery than professionally directed modalities, including affiliation to AA, which were very high, were strong predictors of the respondents' perceived support for their recovery. These feelings, and an identification with the role of care giver in addiction treatment, appeared to be central to their recovery process.

(App J Psychiatry 1991; 147:64-68)

In the United States, psychiatric care for substance abuse has come to rely heavily on peer-led self-help programs, such as Alcoholics Anonymous (AA). There is, however, been relatively little controlled research on the way such modalities operate, given the large numbers of persons involved. There is also a notable paucity of investigations on the way such programs interact with medically directed psychopharmacologic care (1, 2). In order to clarify how peer-led and psychiatric modalities can be effectively integrated, we undertook a study of patients who had been rehospitalized in a treatment system that combined both approaches. We chose the Georgia Impaired Physicians Program because of its longstanding commitment to combining professional care with AA-based peer-led groups, its longitudinal model of rehabilitation from hospital to halfway houses, to aftercare; and its extensive experience, with more than 2,000 patients referred over 13 years from 49 states (3).

METHOD

This study was designed to evaluate a cohort of physicians, alumni of the Impaired Physicians Program, who had elected to attend one of the annual retreats organized by the program's medical directors. Approximately 350 invitations were sent out to recent alumni of the program, and altogether 120 of the inpatients attended. The staff of the program reported that the most common reasons given for not attending the retreats were insufficient time off from work, participation in a previous year's program, previous exposure to the scheduled speakers, conflicting medical conferences, and ill health. In addition, some inpatients were lost because of relocation without change of address or because of refusal to drug use. Participation in the study itself was voluntary and anonymous, and participants were asked by the program director (D.T.) to respond as frankly as possible. It was further made clear that questionnaires would be collected and tabulated by an independent investigator (M.G.) and that only group data would be reported. By means of on-site administration, mailings, and follow-up calls, 116 of 120 participants at the retreat completed a research questionnaire. Of these, 16 were disqualified, one because of a primary diagnosis of bulimia and 13 because they were nonphysician health professionals. The remaining cohort of 100, whose responses are presented here, were recovering physician substance abusers who resided in 29 states and Canada.

The research instrument included 160 multiple-choice or numerical-response items, codable for computerized scoring. The research instrument included items that dealt with demography, professional activity, and drug abuse, as well as the 18-item General Well-Being Schedule, developed and standardized by the National Center for Health Statistics (4). Typical items on this schedule are "Have you been anxious, worried, or upset?" "Have you been waking up fresh and rested?" Responses are given on a 6-point scale. A comparison group (N=315), drawn from a national probability sample developed by Ware et al., was matched to the respondent group for age and sex (5). Also included were attitudinal and self-assessment items, for which responses were made on a 5-point scale (1=not at all, 5=very much), as follows: Treat-
Christian Psychiatry:
The Impact of Evangelical Belief on Clinical Practice

Marc Galanter, M.D., David Larson, M.D., and Elizabeth Rubenstein, B.A.

Objective: The authors surveyed psychiatrists in the Christian Psychiatry movement to assess the role of religious belief in their practices. Method: The psychiatrists were members of the Christian Medical and Dental Society; questionnaires were sent to 260, and usable responses were received from 193. The subjects were asked about demographic and practice variables, "born again" religious experiences, group cohesion, and beliefs about using the Bible and prayer in treatment. Results: The respondents were somewhat more religious than Americans overall, who are themselves more religious than most psychiatrists. Nearly all reported having been "born again," after which they generally experienced a decrease in emotional distress. There was a significant difference in the respondents' affiliative feelings toward psychiatrists in the Christian Psychiatry movement and other psychiatrists. For acute schizophrenic or manic episodes, the respondents considered psychotropic medication the most effective treatment, but they rated the Bible and prayer more highly for suicidal intent, grief reaction, sociopathy, and alcoholism. Whether or not a patient was "committed to Christian beliefs" made a significant difference in whether the respondents would recommend prayer to the patient at treatment. About one-half said they would discourage strongly religious patients from an abortion, homosexual acts, or premarital sex, and about one-third said they would discourage other patients from these activities. Conclusions: Many studies have suggested a need for more sensitivity to religious issues by psychiatrists, and this study provides systematic findings on one approach. It remains important to evaluate ways in which a religious perspective can be related to clinical practice and what benefits and problems may derive from such a relationship.

(Am J Psychiatry 1991; 148:90-93)

A recent resurgence in religious commitment in the United States, including fundamentalism (1), may lead psychiatry to reconsider the place of religious issues in clinical practice. This is particularly relevant to the impact of Christian Psychiatry, a broad-based national movement of psychiatrists who are evangelical Christians. Although most of its adherents are not formally affiliated among themselves, the orientation of this movement is expressed in beliefs espoused by the Christian Medical and Dental Society, which has 7,100 members, 260 of whom are psychiatrists or psychologists in psychiatry residency training. Applicants must sign a statement acknowledging "the final authority of the Bible as the word of God, . . . the presence and power of the Holy Spirit in the work of regeneration . . . [and] the everlasting blessing of the saved and the everlasting punishment of the lost."

Because of the intensity of religious commitment in the Christian Medical and Dental Society, it seems useful to make an independent assessment of the role religious belief plays in the clinical practice of psychiatrists who are members of the society. We also hoped to provide a better understanding of how strong religious belief can affect mental health care.

METHOD

We established an agreement with officials of the psychiatry section of the Christian Medical and Dental Society that we would conduct a study for the purpose...
Medical Student and Patient Attitudes Toward Religion and Spirituality in the Recovery Process

Lisa M. Goldfarb, M.D.
Marc Galanter,* M.D.
David McDowell, M.D.
Harold Lifshutz, Ph.D.
Helen Dermatis, Ph.D.

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ABSTRACT

This study compared the views on spirituality of newly diagnosed patients (diagnosed with both substance abuse and general psychiatric disorders) and medical students in order to investigate their respective orientations toward spirituality and their views of the importance of spirituality in the treatment of addiction. We administered a modified version of Fong’s “Orientation to Life and God Scale” to assess religious and spiritual orientation in both the patients and students. A second series of items was developed and administered in order to compare the patients’ and students’ perceptions of the relative importance of a religious and spiritual orientation in substance abuse treatment. A third series of items was also given to compare the nature of religious and health-related services on the systems with that perceived by patients and students most wanted to see improved. We found that the medical students responded for meeting substance abuse are significantly less religiously and spiritually oriented than the patients they treat, and that the students do not indicate that spirituality is an important component in the care of these patients. It may be clinically relevant to train medical students in the potential importance of spirituality in addiction treatment so that they can incorporate spirituality into the treatment of addiction.

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SERVICIOS
GRATUITOS
HOMBRES Y MUJERES

CENTRAL MEXICANA DE SERVICIOS GENERALES A C.

GRUPO
1º de OCTUBRE

SECCIONES:
DOMINGOS Y LUNES
MARTES Y JUEVES
SABADO
THE TWELVE STEPS OF A.A.

ADMIT
The gogs got me. I'm no longer my own boss.

BELIEVE
Only God can save me from the gogs and straighten me out.

DECIDE TO
Let God have a go in my life.

STEP 1
We admitted we were powerless over alcohol.
That our lives had become unmanageable.

STEP 2
We come to believe that a Power greater than ourselves could restore us to sanity.

I WILLL
Tell God and anyone else the wrong things I've done.

I WANT
God to straighten me out.

STEP 3
Made a decision to turn our will and our lives over to the care of God as we understood Him.

STEP 4
Made a list of people we had hurt and made amends to them.

I TRY
To remember who I've done wrong to and try to put it right.

STEP 5
Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

I WILL
Only but it right if it doesn't hurt anyone.

STEP 6
Went directly to people we had harmed and made amends.

STEP 7
Sought through prayer and meditation to improve our conscious contact with God as we understood Him.

STEP 8
Found strength to continue our new way of living and working as we had come to understand it.

STEP 9
Made a list of all people we had harmed and made amends to them.

STEP 10
Continued to take stock of ourselves and when we are wrong promptly admit it.

STEP 11
Sought through prayer and meditation to improve our conscious contact with God as we understood Him.

STEP 12
Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.
ICYPPOST

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A New Life

Thousands of Young Drunks Storm NYC: Not a Drop in Sight

BADGES MUST BE WORN AT ALL TIMES!

PLEASE USE ESCALATORS AS OFTEN AS POSSIBLE!

INDEX: pg. 2. Welcome pg. 3. General Info pg. 4. Floor Maps
pg. 5 Schedule pg. 6 Schedule pg. 6 Fun Stuff
Members of Alcoholics Anonymous (AA) are typically believed to be middle-aged. This is in keeping with survey data collected by AA itself, which gives the average age of members as 48 years. However, recent interest has emerged regarding the suitability of referral of youthful substance abusers to this fellowship. In this exploratory study, we have evaluated a sample of community-based long-standing youth AA members, independent of their being followed-up from prior treatment. The purpose of this study was to obtain basic information on prior substance use, treatment experience, and duration of abstinence, which has not been generally available for community-based long-term AA samples.

Studies on AA members of all ages are typically limited by the fellowship’s tradition of anonymity and noncollaboration with other organizations, as stipulated in the AA literature and formalized in its Twelve Traditions. Because of this, with few exceptions, access has been effectively limited to members who have been registered and followed-up as part of treatment program outcomes studies. The current study was undertaken on the basis of an understanding reached with a free-standing organization called Young People in Alcoholics Anonymous (YPAA), consisting of youth members of AA who help other youth substance abusers find appropriate ties to the AA fellowship and organize an annual conference. Because many attendees at these conferences have come to AA independent of treatment programs and may be long-standing affiliates of AA itself, access to individuals associated with this organization provides an opportunity to study a population of AA members not usually available for evaluation. It further helps explain certain aspects of AA as a spiritually oriented recovery movement.
Physicians in Long-Term Recovery Who Are Members of Alcoholics Anonymous

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2 State University of New York at Buffalo, Buffalo, New York

Background: There is little empirical literature on the experience of sobriety of long-term, committed members of Alcoholics Anonymous (AA).

Objective: Studies on the experience of long-term members, however, can yield a better understanding of the role of spirituality in AA membership, and how the program helps stabilize abstainers. We studied 144 physicians at a conference of doctors in AA.

Results: Respondents had a mean period of sobriety of 140 months. Compared to non-recuperative populations, they scored higher on scales for depression and anxiety, and were more adherent to the spiritual elements of AA, rather than a formally religious orientation. Those who reported "having a spiritual awakening" were more likely to experience God's presence on most days (81% vs. 19%) and were less likely to report craving for alcohol (21% vs. 40%) than those who did not. Respondents who had a history of being enrolled in State Physicians' Health Programs did not differ significantly on any of the dependent or subjective variables from those who were not enrolled.

Conclusions: The experience of long-term AA members can be characterized in terms of abstinence, spirituality, and alcohol craving, but also by subjective variables. The study of long-term AA members can shed light on mechanisms of achieving sobriety in this fellowship. (Ann J Addict 2011;22:323–328)

An important component of the fellowship of Alcoholics Anonymous (AA) is its long-term, committed membership. These members tend to be strong advocates of the Twelve-Step format, and regular attenders at AA meetings. According to AA's own survey, conducted at a sample of its regular meetings, its members respondents had attended an average of 2.4 meetings weekly, with 47% indicating they had been sober for at least 5 years.

The peer-review literature on AA, on the other hand, does not typically reflect access to long-term members, as it generally describes substance abusers who were followed after referral to AA by ongoing treatment programs. Many such patients do not attend AA with regularity, nor do they stay affiliated for the long term. 4,5 Additionally, such studies typically do not include members who affiliated with AA independent of professional referral.

The current study was designed to characterize a cohort of long-term members, highly committed, and not exclusively referred from treatment or monitoring programs. These respondents are occupationally defined, in that they are all physicians. Although this limits the opportunity to generalize to other committed members, it does provide an understanding of the experience of certain well-rehabilitated AA members in long-term sobriety. Additionally, it characterizes a population of considerable interest from a public health perspective, given the role these physicians play in patient care.

In framing this study, we wanted to address additional issues that are salient to understanding long-term recovery among our respondents. What differences in recovery status might there be between those physicians who entered AA in conjunction with referral by physicians' health programs, and those who did not? What are some aspects of alcohol craving and affective states (such as depression) as correlates of the recovery experience? What role does spirituality play in the recovery process? Spirituality in particular is important to AA—a self-designed spiritual fellowship—but is an issue which merits some clarification because of the subjective nature of its experience, and the limited empirical literature on this issue.

METHOD

The study was designed to be in accord with the 12th AA tradition, the need to preserve members' anonymity. This was done by not soliciting names of the participants, and surveying them in such a way that they could not be individually identified by the responses they gave to the research instrument we employed.

The study was carried out at a scientific session, providing continuing medical education, of an association of health professionals. Information on this association is publicly available.

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NARCOTICS ANONYMOUS: A COMPARISON OF MILITARY VETERANS AND NON-VETERANS

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Substance use disorder, which is often comorbid with post-traumatic stress disorder (PTSD), is a problem confronted by many veterans. To determine the potential utility of Narcotics Anonymous (NA) for veterans, 508 NA attendees were studied. Veterans (n = 172) were more likely to have been referred by a professional than were non-veterans (77% vs. 22%, respectively); 76% had been hospitalized for alcohol or drug problems, and 51% had been treated for non-substance psychological problems. The 70% of veterans who reported at least 1 of 3 service-related stressful experiences were more likely to report PTSD-related symptoms. NA can serve as a recovery resource for certain veterans with substance use disorders, with or without PTSD.

KEYWORDS: Addiction, veterans, narcotics anonymous, post-traumatic stress disorder

INTRODUCTION
Considerable public concern has recently been focused on the problems of veterans with substance use disorders, which are often comorbid with post-traumatic stress disorder (PTSD). In addition, there has been a focus in the peer-reviewed literature.1-4 We have reported previously on the role of Narcotics Anonymous (NA) in addiction recovery5,9 and on the relatively small portion of attendees (35%) at NA meetings who were referred to NA by professionals; this suggests that there may be a population of veterans whose substance use and PTSD were addressed in the fellowship of NA and not necessarily through professional referral. An evaluation of community-based veterans’ use of NA for symptom relief may, therefore, provide useful information on a way of enhancing existing treatment programs.

In light of this, we conducted interviews and focus groups with veterans attending NA, and this experience suggested that there were veterans in this 12 Step fellowship who had experienced relief from substance use disorders, often comorbid with symptoms compatible with PTSD. However, empirical research on this aspect of veterans’ recovery has not been reported in the peer-reviewed literature. This is evident even in studies of the value of interpersonal support in mitigating such symptoms.10-15 In light of this, we solicited Narcotics Anonymous World Services to cooperate in accessing NA groups across the United States that NA staff knew might have at least some members who were veterans, thereby allowing for evaluating veteran and non-veteran members who participated together in the fellowship.

METHOD
Participants
The Narcotics Anonymous World Service Office, located in Chatsworth, California, agreed to select a diverse group of U.S. meetings that were likely to have participants who were veterans. Coordinators of those meetings were asked by the leadership to distribute a survey instrument
Spiritual Awakening in Alcoholics Anonymous: Empirical Findings

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Spiritual awakening, a key aspect of 12-Step recovery, is designated in the 12th Step of Alcoholics Anonymous (AA). The authors applied a psychiatric survey instrument to 161 long-term AA members who reported having had such an awakening. Sixty-seven percent of respondents reported no craving for alcohol or drugs at the time of the survey. Their awakening had most often taken place gradually (60%) while they were working the Steps (52%) and right after becoming sober (57%). Their response reflected a major experiential transformation, including highly significant changes in craving and depression and increases in service to other AA members. A factor analysis of descriptors of the awakening revealed the following six dimensions of the experience, with variability across respondents: positive mood, abstinence, interpersonally related, a sensory experience, God-related, and related to personal meaning. Findings showed that it is feasible to characterize communities in the nature of a spiritual awakening as a major transformative event across many long-term AA members, though the specific character of the experience differs across individuals.

KEYWORDS Alcoholism, recovery, spirituality, Alcoholics Anonymous

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Alcoholics Anonymous and Twelve-Step Recovery: A Model Based on Social and Cognitive Neuroscience

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Background: In the course of achieving sobriety from alcohol, longstanding members of Alcoholics Anonymous (AA) typically experience a change in their attitudes, values, and behaviors. These changes are not just reflective of psychological mechanisms but also of social and cognitive neurological mechanisms. This article is designed to examine recent findings associated with these disciplines that may shed light on the mechanisms underlying this change.

Methods: Literature review and hypothesis development.

Result: Pertinent aspects of the neural impact of drugs of abuse are summarized. After this, research regarding specific brain sites, elucidated primarily by imaging techniques, is reviewed relative to the following: mourning and mentalizing are described in relation to the neurocognitive models of self-schema development, and value formation. A model for attrition to a Higher Power is presented.

Discussion: The phenomena associated with AA reflect greater complexity than the empirical studies on which this article is based and certainly require further exploration. Despite this substantial limitation in currently available findings, there is heuristic value in considering the relationship between the brain-based and clinical phenomena described here.

Conclusions: There are opportunities for the study of neurocognitive correlates of Twelve-Step-based recovery, and these can potentially enhance our understanding of related clinical phenomena. (Am J Addict 2013;22:1-8)

INTRODUCTION

Addiction is a chronic illness subject to relapse. Because of this, providing long-term support for remission is a key element in how our society can address this major public health problem. At present, Twelve-Step Fellowships provide such a resource and, importantly, no requisite cost burden on government, insurers, or individual members. Alcoholics Anonymous (AA), which originated in 1935, is the source of this format for recovery, with some two million members worldwide and 200,000 weekly meetings. Narrators Anonymous, which employs the same Twelve-Step format, reports over 56,000 meetings worldwide.

This article is intended to suggest possible links to the way certain biologically grounded mechanisms, empirically derived, can play a role in the way that such fellowships achieve their effectiveness. For this, we will turn to a body of research of relatively recent origin which can be broadly subsumed under the rubric of social and cognitive neuroscience. This discipline draws on basic biological mechanisms to explain the way both cognitive processes and social interaction underlie much of the behaviors observed in numerous species, humans included.

We will begin with a brief summary of mechanisms directly associated with the disease of addiction, to distinguish the pathological process itself from a hypothesized model of the reparative process that can take place among AA members. We will then describe empirical findings related to the processes of mourning and of mentalizing which allow for understanding another person’s experience as it relates to empathic encounter. These can be subsumed under a broader approach, termed Theory of the Mind. This then leads to an examination of how new memories that relate to the cognitive aspects of the Twelve-Step process can be laid down and integrated into broader schemas that represent perspectives on how the recovery process can be achieved. Finally, we will consider the way the aforementioned processes relate to the ritual of storytelling in AA, and the acceptance of a ‘Higher Power’ by its established members.

To be clear, many of the biological processes described here have been studied with regard to stress and responses much less complex than those incorporated in an elaborate social structure like AA. Their applicability to AA itself may therefore draw on additional brain sites relevant to these broader issues.
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An initial fMRI study on neural correlates of prayer in members of Alcoholics Anonymous

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ABSTRACT

Background: Many individuals with alcohol-use disorders who had experienced alcohol craving before joining Alcoholics Anonymous (AA) report little or no craving after becoming long-term members. Their use of AA prayers may contribute to this. Neural mechanisms underlying this process have not been delineated. Objective: To define experiential and neural correlates of diminished alcohol craving following AA prayers among members with long-term abstinence. Methods: Twenty AA members with long-term abstinence participated. Self-report measures and functional magnetic resonance imaging (fMRI) of differential neural response to alcohol craving-inducing images were obtained in three conditions: after reading of AA prayers, after reading irrelevant news, and with passive viewing. Random-effects robust regressions were computed for the main effect (prayer × passive × news) and for estimating the correlations between the main effect and the self-report measures. Results: Compared to the other two conditions, the prayer condition was characterized by less self-reported craving, increased activation in left anterior middle frontal gyrus, left superior parietal lobule, bilateral precuneus, and bilateral posterior middle temporal gyrus. Craving following prayer was inversely correlated with activation in brain areas associated with self-referential processing and the default mode network, and with characteristics reflecting an AA program involvement. Conclusion: AA members' prayer was associated with a relative reduction in self-reported craving and with consistent engagement of neural mechanisms that reflect control of attention and emotion. These findings suggest neural processes underlying the apparent effectiveness of AA prayer.

Introduction

Alcoholics Anonymous (AA) is an abstinence-oriented fellowship with over 1.2 million members in the United States, of which 73% report over 1 year of abstinence, and attend an average of 2.6 meetings weekly (1). Narcotics Anonymous also employs the Twelve Step approach, and meeting attendees report an average of 6.1 years of abstinence (2).

The majority of long-term Twelve Step members who have surveyed report no alcohol or drug craving: for AA, 79% reported no craving for alcohol (3,4), and for NA, 49% reported no craving for alcohol or drugs (2). This is notable, since people joining and persisting in attending these fellowship meetings are among the more severely addicted, having suffered from considerable craving for their principal substances of use. In fact, "craving, or a strong desire to use alcohol (or another drug)? is one of the formal criteria for diagnosing an addiction in the diagnostic manual of the American Psychiatric Association (5). Unlike other criteria, it is listed as potentially persisting, even in an addicted person in remission. In light of this, a framework based on recent neural findings can be constructed to encompass the impact of the Twelve Step experience on the recovery process (6). The diminution of craving in long-term Twelve Step members therefore merits investigation to ascertain the nature of craving, an important aspect of persistent remission.

Craving

Assessments of cue reactivity and craving have typically been conducted on subjects who are either non-treatment seeking, in a detoxification unit, or in treatment, as reflected in a recent review of 28 such studies (7). Findings in these studies illustrate how craving is...
**Prayer**
Regulates the acquired emotional response by exercising a reappraisal of the emotional response to triggers by activating areas for:
(a) regulation of attention
(b) Semantic control of emotion
Combining medially assisted treatment and Twelve-Step programming: a perspective and review

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ABSTRACT

People with severe substance use disorders require long-term rehabilitative care after the initial treatment. There is, however, a deficit in the availability of such care. This may be due to the lack of integrated medical care and insufficient use of community-based Twelve-Step programs in many treatment facilities. In order to address this deficit, rehabilitative care for severe substance use disorders could be promoted through collaboration between practitioners of medically assisted treatment, employing medications, and Twelve-Step-orientated practitioners. Strategies for the limitations and benefits in applying medical approaches and Twelve-Step approaches can be employed together to improve clinical outcomes. Methods involving in available treatment options in ambulatory and residential treatment settings for patients with severe substance use disorders, including co-occurring conditions, are evaluated to discuss the relative effectiveness of medical and Twelve-Step approaches. Clinical trials for enhanced care of these approaches, singly and in combination, to address prevalent medical and social problems are evaluated. The tradiomedical and Twelve-Step-oriented approaches, and their potential for extending care to broader populations, are discussed. This report highlights opportunities for improving addiction healthcare with collaborative practices. Further research is needed to develop improved clinical outcomes.

This paper presents a perspective and a review of findings related to the need for better communication between physicians practicing medically assisted, medication-based treatment and practitioners of Twelve-Step-oriented treatments. We will consider how both groups have much to offer, in terms of promoting recovery from substance dependence, and how collaboration between the two can improve outcomes for long-term abstinence. Broadly speaking, this is most relevant to the reported 3% of persons with substance use disorders who do not receive adequate treatment (1). More specifically, the need for improved collaboration is most evident among people with a lifetime prevalence of severe alcohol (5.4%) and illicit drug (3%) use disorders (2). It is this latter clinical population, compromised by a life-threatening medical disorder, who constitute the majority of persons who die from substance dependence (3), and incur the largest portion of the estimated $466 billion cost in the US for substance use problems (4).

Background

A deficit in integration across groups of Twelve-Step and medication-oriented clinicians arose historically because the Twelve-Step approach emerged in the 1930s, at a time when there were no medications available to support rehabilitation of persons with alcohol dependency. The Twelve-Step approach then became embedded in the treatment community as part of the culture of recovery from alcoholism. It was only over ensuing decades that medications for promoting abstinence from alcohol use disorders were developed, and that the Twelve-Step approach came to be applied to other dependency-producing drugs.
CONCLUSIONS

1. Biologic entities exist at different levels of integration – from neural structure to social systems.

2. Addiction and recovery can, as well, be understood from multiple levels of integration: physiologic, bio-behavioral, and interpersonal.

3. In approaching addiction treatment, we need to appreciate how biologically grounded change can be mediated on these respective levels.

4. Family networks and Twelve Step groups are therefore examples of biologically grounded approaches for remediation of addiction.