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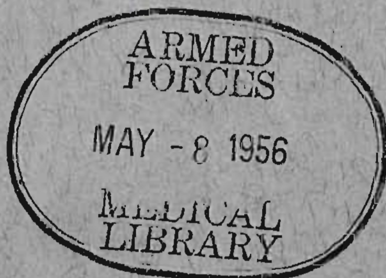
COMMITTEE ON DRUG ADDICTION AND NARCOTICS

Minutes of Seventeenth Meeting

30 and 31 January 1956



National Academy of Sciences - National Research Council
Division of Medical Sciences
Washington 25, D. C.

NATIONAL ACADEMY OF SCIENCES - NATIONAL RESEARCH COUNCIL
Division of Medical Sciences

COMMITTEE ON DRUG ADDICTION AND NARCOTICS

Minutes of the Seventeenth Meeting - 30 and 31 January 1956
National Academy of Sciences
Washington, D. C.

Open Session

ATTENDANCE:

Committee:	Dr. Isaac Starr, Chairman Hon. H. J. Anslinger, Drs. Raymond N. Bieter, Dale C. Cameron, Nathan B. Eddy, Joseph M. Hayman, Jr., Maurice H. Seevers and Lyndon F. Small.
	(Absent): Dr. Erwin E. Nelson
Liaison Representatives:	
American Drug Manufacturer's Association:	Mr. Karl Bambach
Bureau of Narcotics:	Mr. Alfred L. Tennyson, Chief Counsel
Food and Drug Administration:	Drs. Albert H. Holland, Jr., and Ernest Q. King.
Office of Naval Research:	Mrs. B. H. Caminita, Biochemistry Branch.
U. S. Army:	Capt. R. W. Babione, USN, Armed Forces Epidemiological Board; Col. R. P. Mason and Dr. S. Bayne-Jones, Research and Development Division; Col. D. B. Peterson and Maj. K. W. Morgan, Neuropsychiatric Consultants Division; Office of the Surgeon General. Dr. L. R. Goldbaum and Capt. R. L. Mundy, Department of Biochemistry, Physiology and Pharmacology Division, Walter Reed Army Institute of Research, Walter Reed Army Medical Center.
U. S. Public Health Service:	Dr. George F. Archambault

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Guests:

Drs. J. Axelrod, Kenneth W. Chapman, Joseph Cochin, Conan Kornetsky, Everette L. May, Lewis J. Sargent and Mr. T. D. Perrine, National Institutes of Health.
Drs. Henry K. Beecher and Franklin F. Snyder, Harvard University.
Dr. Hylan A. Bickerman, Columbia University.
Mr. Gerald A. Deneau, University of Michigan.
Dr. H. F. Fraser, Addiction Research Center, Lexington, Ky.
Dr. R. G. Grenell, University of Maryland.
Dr. Raymond W. Houde and Mr. Stanley Wallenstein, Memorial Center, New York.
Dr. Arthur S. Keats, Jefferson Davis Hospital, Houston, Texas.
Dr. Laurence Kolb, U.S. Public Health Service,(retired), Washington, D. C.
Drs. Louis Lasagna, Victor Laties and M. Shepherd, Johns Hopkins University
Drs. Lyndon E. Lee, Jr. and W. W. Glas, Wayne County Hospital, Eloise, Mich.
Dr. Marie Nyswander, Postgraduate Center for Psychotherapy, New York University
Dr. Maurice S. Segal, Boston City Hospital.

Drug Manufacturers' Representatives:

Abbott Laboratories,
Drs. Rodney P. Gwinn and R.K. Richards.
Bilhuber-Knoll Corp.
Dr. R. O. Hauck.
Bristol-Meyers Co.,
Drs. Raymond L. Cahen and Walter B. Elvers.
Burroughs-Wellcome & Co.
Mr. Howard B. Fonda and Drs. Edwin J. de Beer and John C. Seed.
Ciba Pharmaceutical Products, Inc.
Drs. Jurg A. Schneider and F. F. Yonkman.
Endo Products, Inc.
Dr. M. J. Lewenstein.
Hoffmann-La Roche, Inc.
Drs. John Aeschlimann, Leo A. Pirk and Mr. Manly Sheppard

Lilly Research Laboratories,
Drs. Charles M. Gruber, Jr., Albert H. Pohland and Mr. E. Brown Robbins.
Mallinckrodt Chemical Works,
Dr. Melvin A. Thorpe.
Merck & Co., Inc.,
Mr. W. Edwin Clapham, Drs. Frederick K. Heath, Peter Orahovats, Karl Pfister and Robert F. Sterner.
The Wm. S. Merrell Co.,
Dr. Harold W. Werner.
Miles-Ames Research Laboratories,
Dr. Otis E. Fancher.
New York Quinine and Chemical Works, Inc.
Mr. J. B. Flanagan and Dr. Manuel Baizer
Parke, Davis & Company,
Dr. L. M. Long
S. B. Penick & Co.,
Dr. W. G. Bywater.
Philadelphia Ampoule Laboratories,
Drs. R. L. Felton and Thomas J. Fenwick.
Schering Corporation
Drs. Sam Irwin, Marion Slabok and Gordon Thomas.
Sharp & Dohme, Inc.
Dr. John R. Beem.
Smith, Kline & French Laboratories,
Dr. Paul A. Mattis.
Sterling-Winthrop Research Institute,
Dr. Joseph G. Bird.
The Upjohn Company,
Drs. William B. Bass, M. J. Vander Brook and Joseph P. Webb.
Warner-Chilcott Research Laboratories,
Dr. Jane F. Emele.
Winthrop-Stearns, Inc.,
Dr. A. Scribner.
Wyeth Laboratories,
Drs. M. Bierly, Jr. and Richard Tislow.

National Academy of Sciences - National Research Council: Drs. Jonathan O. Cole and Philip S. Owen.

The open session of 30 January, Dr. Isaac Starr, Chairman, presiding, convened in the lecture hall of the National Academy of Sciences at 10:15 a.m. The following reports were presented and discussed:

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1. Studies on Narcotics, Annual Report. By Dr. Henry K. Beecher, Massachusetts General Hospital, Boston, Mass.

   a. Preliminary report on piperidyl methadone. See Appendix A, p. 1381.
   b. Analgesic power and toxic effects in man of dihydrocodeine and dihydroisocodeine compared with morphine and a placebo. See Appendix A, p. 1308.
   c. Relationship of significance of wound to pain experienced. See Appendix A, p. 1330.

2. Clinical Studies of Narcotics at Memorial Center. By Dr. Raymond W. Houde and S. L. Wallenstein, Division of Clinical Investigation, Sloan-Kettering Institute for Cancer Research, New York, N. Y. See Appendix B, p. 1383.

3. Progress Report on Establishment of New Clinical Facility for Testing Analgesics. By Dr. Lyndon E. Lee, Jr., Wayne County Hospital, Eloise, Michigan. See Appendix C, p. 1404.

1:45 p.m. Presentation and discussion of reports continued:

4. Individual Differences in Response to Drugs. By Dr. Sam Irwin, Schering Corporation, Bloomfield, N. J. See Appendix D, p. 1410.

5. The Effects of Several Centrally Acting Drugs on Certain Psychological Functions. By Dr. Conan Kornetsky, National Institute of Mental Health, National Institutes of Health, Bethesda, Md. See Appendix E, p. 1424.

6. Nalorphine, a Potent Analgesic in Man. By Dr. Arthur S. Keats and Jane Telford, Jefferson Davis Hospital, Houston, Texas. See Appendix F, p. 1433.

7. Drug Action and the Mechanism of Narcosis and Anesthesia. By Dr. R. G. Grenell, University of Maryland, Baltimore, Md. See Appendix G, p. 1442.

8. The Use of Narcotine as an Antitussive Agent. By Drs. Maurice S. Segal, Merrill M. Goldstein, and Ernest O. Attinger, Tufts University School of Medicine and the Lung Station (Tufts) and Department of Inhalation Therapy, Boston City Hospital, Boston, Mass. See Appendix H, p. 1451.

The meeting adjourned at 4:15 p. m.

The 31 January continuation of the open session was called to order by the Chairman, Dr. Isaac Starr, at 9:30 a.m. in the lecture room of the National Academy of Sciences. The following reports were presented and discussed:

1. Annual Report on Studies in the Monkey (Macacca mulatta) Designed to Determine the Value of This Animal for Predicting Addiction Liability to the Newer Synthetic Analgesics. By Dr. M. H. Seevers and Gerald Deneau, Department of Pharmacology, University of Michigan, Ann Arbor, Michigan. See Appendix I, p. 1464.

2. Work at the NIMH Addiction Research Center, Public Health Service Hospital, Lexington, Kentucky, Calendar Year 1955. By Drs. H. F. Fraser and Harris Isbell, Lexington, Ky. See Appendix J, p. 1479 and the addendum to the minutes following p. 1496.

3. A Research Project on the Treatment of Drug Addicts. By Dr. Marie Nyswander, Postgraduate Center for Psychotherapy, New York University, New York, N. Y. See Appendix K, p. 1484.

The open session adjourned at 11:15 a.m.

Executive Session

Attendance:

Committee: Dr. Isaac Starr, Chairman
Drs. Raymond N. Bieter, Dale C. Cameron, Nathan B. Eddy, Joseph M. Hayman, Jr., Maurice H. Seevers, and Lyndon F. Small.

(Absent): Hon. H.J. Anslinger and Dr. Erwin E. Nelson.

Bureau of Narcotics: Mr. Alfred L. Tennyson.

Food and Drug Administration: Dr. Albert H. Holland, Jr.

U. S. Public Health Service: Dr. H. F. Fraser.

National Academy of Sciences - National Research Council: Drs. R. Keith Cannan, Jonathan O. Cole, and Philip S. Owen.

Dr. Starr called the meeting to order at 11:40 a.m. in the Board Room of the National Academy of Sciences.

1. Habit-forming as distinguishable from addiction-producing property. Letter of Dr. Albert H. Holland, Jr., Food and Drug Administration.

Dr. Eddy noted that this item was a carry-over from the last meeting. Dr. Holland's letter was received 9 January 1956 and copies of it were sent to the Committee members immediately thereafter. There was, therefore, hardly time for the return to the secretary of individual comment, as had been suggested. Appendix L, p.1494 was offered simply as a basis for discussion.

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APPENDIX K

A Research Project on the Treatment of Drug Addicts

by

Dr. Marie Nyswander
Narcotic Addiction Research Project sponsored by
National Advisory Council on Narcotics, New York, N.Y.

This research project was launched early in October of 1955. Its purpose is to study the treatability of the confirmed drug addict outside of the hospital.

This study was deemed relevant for several reasons: Because of successful experiences reported in the literature, the refusal of community agencies to accept these patients, and the prevalent stereotype pattern of treatment which has been advocated for all addicts.

There has been some related work which I would like to review briefly. The New York University Research Center for Human Relations has been conducting an epidemiological study in New York City of sociological factors in adolescent drug addiction. Some steps are being taken to construct a psychiatric profile of adolescent addicts, based on psychiatric interviews.

The University of Rochester has been conducting a study on changes in motivational systems and personality as they are affected by chemical agents. The focus of the study has been on the measurement of the changes rather than on long-range effects.

Commencing in 1951 and 1952, studies were conducted on outpatient-psychotherapy of addicts at several hospital facilities in the Chicago area. The Provident Hospital, under psychiatrist Dr. Walter J. Adams, has had a clinic for the treatment of drug addicts. The Montgomery Ward clinic of the Northwestern University Medical School, under Dr. Benjamin Boshes, has conducted some clinic therapy and is now planning follow-up work including group therapy for addicts in a local prison. Dr. Clifford Shaw at the Institute for Juvenile Research has conducted intensive interviews with a number of male juvenile delinquent users of drugs.

It will be seen from this that no concerted attempt to examine specific hypotheses and variables dealing with the outpatient therapy of narcotic addicts has ever been undertaken on a continuing basis.

The literature on the subject of psychiatric treatability plus non-published experiences of individual physicians indicate the possibility that successful treatment can be done with drug addicted patients . . . . on an ambulatory basis. For example, the following is a typical patient applying to our study:

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This patient was a 24-year old male, married, with a 3-year old son. He had been referred by Narcotics Anonymous who persuaded him to seek help after his release from prison. His history was typical in that truancy and school failure began in the second year of high school. His major activities concerned his gang and he related with great pride that he was the leader of the "brain" gang and had been in newspapers and on television. He had served a total of several years in prison for possession of drugs. Psychiatric therapy was commenced on a twice a week basis, the patient often coming to sessions half asleep from drugs.

The therapist soon found out that through all these years the patient had been sneaking away from his gang and going to the library where he had read all the psychological books he could. The patient had glasses but refused to wear them lest he be called a sissy. He dressed in a zoot suit and a pompadour hairdo. Within three months after the beginning of therapy the patient was wearing his glasses all the time and expressing a sincere desire to go off drugs. He reduced himself to one shot a day but seemed unable to stop entirely. With great determination he persuaded one of the city hospitals to admit him for a week. After discharge from the hospital he went back to school and finished his high school requirements. During the course of therapy he relapsed to the use of drugs several times but always managed to withdraw himself. He has worked steadily and drug free for the past three years.

Papers by Fenichel, Winkelstein and Savitt suggested that this type of treatment should be explored further with a larger series of cases.

The second reason for the study is the fact that a stereotype about the treatment of the drug addict not only exists but is the excuse given by psychiatrists as well as by psychiatric clinics for their not treating the patient on an outpatient basis. Inasmuch as psychiatrists and analysts have only reported their therapeutic results irregularly no real generalizations are possible about their experiences. There is in fact some disagreement over the best method for treating narcotic addicts even among the few psychiatrists who have done so.

Our only body of experience in the treatment of drug addiction in the United States has led us to three main conclusions. These conclusions seem to be the result of experiments which have included the compulsory hospitalization of the addict: These are: a. The belief that the drug addict must always be withdrawn in a hospital prior to his commencement of further therapy. b. That such hospitalization should optimally require about four months. c. That the prognosis as compared with other psychiatric illnesses is poor.

The third reason why the study was deemed necessary was to test the usability of non-medical therapists in the treatment of the emotional disorders of the addict. The entire process has generally been considered the province of the physician because of the physiological nature of addiction proper.

Basic Assumptions

The basic assumptions of the project are threefold: 1. That drug addiction is a symptom and a way of reacting to an underlying emotional disturbance. From this assumption the experiment proceeds to explore the fact that the psychoanalytic method of treatment might be the method of choice in treating drug addiction.

2. The second assumption of the project is that analytically trained lay therapists can work equally well as psychiatrists in the analytical treatment of drug addicts.

3. The third assumption involves a general belief in psychiatric treatment, that is, that therapy with addicts as with all other psychoneurotic problems, should be planned according to the specific problems of the individual patient.

The project has been set up in New York City *to duplicate* as far as possible, the same resources that would be available in the treatment of *any* psychoneurotic problem . . . such as alcoholism, anxiety neurosis, etc. These resources include twenty-five volunteer therapists from three fields: psychology, social work and psychiatry. The common discipline which they share is the psychoanalytic procedure. Their qualifications include graduate degrees plus a minimal four years of psychoanalytic training and practice in treatment.

The patients are seen in the private offices of the therapists or at the Postgraduate Center for Psychotherapy clinic.

Patients are referred to this project from a variety of sources. These include the courts, prisons, Lexington, the County Medical Association, private agencies, private practitioners, Churches, Federal Probation Officer, etc. Since the literature contains no data by which one could determine those patients most likely to be aided successfully it was decided to take all comers who had evinced any wish for treatment. At least for the present, therefore, no patient is eliminated for any reason, even though it be the wish to evade a court sentence, compliance with family wishes, etc.

Fees are nominal with the patient. However, to reflect the usual psychoanalytical situation some charge is made for every patient even though it be only fifty cents. The average fee at present seems to be about two dollars.

Collection of Data

The records kept are in three parts. These are The Initial Interview, Session by Session Progress Report, and a Final Summary.

The Initial Interview is conducted on every patient by the supervisor of the project. The data include age, sex, occupation, education, marital status, salary and occupation of mate (other source of income) military record, family

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constellation, source of referral, previous therapy, and/or hospitalizations, history and development of complaint, family and work history, chief complaints, significant dreams and previous emotional upsets. The drop-out rate is kept by the Initial Interviewer.

The progress report is kept by the individual therapist and is a summary of the pertinent psychoanalytical material adduced in daily sessions. These data of course, include such material as dreams, attitudes towards drugs, changing attitudes, whether and how withdrawal occurs and all other relevant material.

The final summary also is kept by the individual therapist and is filled out when the patient leaves therapy for whatever reason. Its data include reason for termination of therapy, course of treatment (main line of therapy and areas dealt with) type of therapy done, effect of therapy on symptoms, adjustment to environment, physical functions, relations with people, unusual events occurring during therapy (interruptions of treatment, changes of therapist, any major decisions of patient, etc.), number of therapeutic sessions per week and psychiatric dynamics of the case. These data include also the method the therapist used in handling the addiction proper, i. e. whether he insisted on withdrawal, ignored the symptom, etc.

Supervision of the therapist takes place on two levels. One, in individual sessions; and two, at monthly staff meetings where cases are reported.

Project Outline

The procedural method of the project is planned around two groups of addicts of fifty each. In the initial phase of research all addicts who appear for therapy will be accepted since it is desired to have as wide an addict range as possible. Before and after questionnaires will be administered to both therapists and patients. The questionnaire to the patients will try to develop their preconceptions about psychotherapy and psychotherapists before and after therapy. The questionnaires to the therapists will get at their preconceptions about drug addiction and the treatment of drug addicts. A questionnaire administered to the therapist after one year of treating addicts will show how their attitudes have changed as compared with the pre-therapy baseline questionnaire.

Scientific measuring devices will be used before, during, and after the psychotherapy process wherever feasible. Q-sort procedures will be used to study the changes in the self-concept of each patient as this self-concept changes in the therapy situation. Factor analysis and analysis of variance will be used on the Q-sort material.

In order to develop a screening interview guide which may be helpful in any future work with addicts, a forced choice rating scale designed to spell out the dynamic factors entering into prognosis will be used. The progress of the therapy will then be checked against the predictions made on the basis of the rating scale.

The therapy sessions will be recorded and standard techniques of content analysis will be used to study what took place during each therapy period. Changes in the distress-relief quotient will be identified from the analysis of the recorded therapy hours.

Dependent upon the findings from this first series of fifty patients the treatment procedure with the second series of fifty addicts will either remain the same or will be modified according to the experiences of the first series.

Criteria for the Evaluation of Treatability

The criteria of treatability, it was felt, could be the same for the drug addict as for other severe psychoneurotic disturbances. These are then: 1. The length of time which the patient remains in therapy. 2. The capacity to establish a cooperative working relationship with the therapist. 3. Positive changes in the large areas of the patient's functioning in work, social life, sexual adjustment, family relationships. 4. Intra-psychic changes as evidenced by observable affectual material. 5. His handling of the drug addiction and the phenomenon of relapses.

I have stated thus far the why and how of this project and have attempted to list the criteria by which we intend to evaluate the treatability of the drug addict by means of a variety of psychoanalytical procedures. While it may seem pertinent to include the nature of the psychoanalytic method; that was considered premature at this point and would definitely constitute material for further investigation. This present project is designed only to study whether the confirmed addict is treatable outside the hospital with psychoanalysis in any form, not to determine the best and most applicable form.

I think that at this point a minor bit of speculation might be forgiven. If the results of the project should prove to be positive we might then retroactively consider it a worthwhile endeavor. It would have served as a demonstration project indicating the extent to which available community facilities could be used in handling drug problems. And too, if positive results are obtained, the project would have been the beginning of a training program for therapists in the management and treatment of the very serious medical problem of drug addiction.

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PUBLICATION REFERENCE

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Fenichel, O. The Psychoanalytic Theory of Neuroses. New York, W. W. Norton, 375-386, 1945.

Savitt, Robert A. Extramural Psychoanalytic Treatment of a Case of Narcotic Addiction. Journal of the American Psychoanalytic Association, 2:3, 494-502, 1954.

Winkelstein, Charles. Psychotherapy of a Borderline Schizophrenic with Heroin Addiction. Presented before the Society for Clinical Psychiatry, Hillside Hospital, March 1955.

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Discussion

Dr. Starr: I am delighted that psychiatrists are becoming interested in this approach to the problem. I have noticed that my psychiatric friends have generally said that they burned their fingers, got nowhere and were anxious not to try again. The ordinary practitioners, when an addict comes to his office, is concerned only with getting him out of it.

Dr. Chapman: I have been working for the last six months on trying to encourage the states to take over some of the burden of treating narcotic addicts. For the past 30 years it has been primarily the concern of the Public Health Service to try to treat these people sort of in vitro. I use that word advisedly because we have been committed to a program of long continued institutional treatment on account of the lack of facilities to which we can refer patients after treatment has been started at Lexington. Hence it is with considerable enthusiasm that I hear of the initiation of this work by Dr. Nyswander. Everyone that I have talked with is happy over the possibilities, on any score, whether from a humane standpoint or for purely economic reasons, if a method can be worked out for treatment of the addict in the community. Treatment costs $7.00 a day at Lexington, $30.00 a day at Riverside Hospital. Probably not all patients can be handled as Dr. Nyswander suggests, but if some have to be hospitalized and the stay in hospital can be shortened, that alone is of very great importance.

-------: I wonder if Dr. Nyswander has considered a control group, treated as heretofore, or not treated, for comparison with her procedure?

Dr. Nyswander: We are interested for one thing in the drop-out rate because of the general prejudice by clinicians that these people are unreliable. We are trying to duplicate what is done in all good psychiatric agencies, determine our drop-out rate, and then compare the result with the drop-out rate for persons seeking psychoanalytic treatment for any reason. We thought we could compare too, within the same group, our results with those demonstrated in the follow-up study on persons discharged from Lexington.

-------: I think the result would be clearer if you put a part of your subjects simply on a program of supportive treatment. I am inclined to think the result would be the same.

Dr. Nyswander: There are already reports of failures with supportive therapy. Youth House closed down in a year. They did not, however, have people adequately trained to deal with the problem. Reports on similar groups in prisons and clinics have not been satisfactory.

Dr. Eddy: Would it not be possible to treat as you propose on the one hand patients who have been to Lexington and come to you on discharge from there, on the other hand, persons who come to you without previous institutional treatment and compare both with discharges from Lexington for whom nothing particularly is done. Is it too early to ask how many patients have been treated and whether anything can be said about results.

Dr. Nyswander: This has all been on a voluntary basis so far. I see about three addicts a week. About 30 are under treatment at present. They come to us in all sorts of ways but all have wanted or have expressed a desire to come off drugs. About half have come off. The difficulty in some cases is that we can't find a hospital to take them and they don't want to go to Lexington. It looks very favorable considering that the patients we take are not screened in any way. Our drop-out rate is about 50 percent which we think is very good under these circumstances.

As to the attitude of psychiatrists toward addicts, we sent out a questionnaire to psychiatrists and to physicians generally. All psychiatrists had the feeling that addicts were untreatable; physicians also expressed a hands off policy. On the other hand lay analysts said, "Why not!" and they are getting good results. Perhaps a factor is that physicians can write prescriptions and the addict is always hoping to get one; the lay analyst can't write a prescription and the addict knows it.

Dr. Kornetsky: Are these people you are treating under pressure in any way to take psychotherapy, are they probationers, or are they otherwise threatened with going to jail? If a patient under psychotherapy relapses, do you write a prescription? How do you handle this problem?

Dr. Nyswander: No to the first question. That is the point of the project. We don't turn anyone down. We have several boys in the group from Riverside who have revolted against any institution. Many of these are very amenable to our type of therapy. At present our work does not involve the giving of drugs. We are interested in whether the giving of drugs can be arranged, we don't see how it can be, and whether if drugs could be given this would be abused. We have no evidence that it would be. The only medication which I prescribe is an occasional nembutal. The therapy seems to be working because they are quite determined to get off drugs.

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Dr. Kornetsky: There was a case of an addict getting drugs as he wished but up to a certain date only. He withdrew himself and then just the day before the period of administration was to terminate started taking as much as he could get for that last day.

Dr. Nyswander: Our patients cut themselves down. They go to work within a week. They all say they want to go to work quickly.

Dr. Cameron: I am indeed very pleased to hear about this study and although it is not hedged in with all the controls we would like it is worth doing. There are some control problems which have already been touched on. One that troubles me is the self-selection, or the way your patients get to you. I would assume you would have a very biased group. It would be interesting to make some study of the motivation in your group in contrast to that of a group in Lexington. Another is the effectiveness of psychoanalytic compared to any supportive therapy. You already have some lead on this. Another thing I wonder about is the validation of what the individual tells the therapist. Do you have individual social workers, for example, checking with the family to find out whether what the individual tells you about his progress or reduction in drugs is true? We have thought the drug addict was an unreliable informant.

Dr. Nyswander: At Lexington we did feel that way about the addict; in private practice where there is no compulsion they don't seem to be unreliable. There is no reason for them to lie; they don't get a gold star for on drugs or off. It is made clear that the therapist is not concerned whether they are on drugs or off. In this way we try to remove ourselves from any personal entanglement. We continue with the patient even if he says he has relapsed to drugs.

Dr. Cameron: If your assumption is correct that they are not under any pressure, then I would agree with you that you can accept their statements. On the other hand, I think there will be some who will come to you under pressure. The judges are beginning to send them to you. In such cases I wouldn't be so certain.

Dr. Lewenstein: Have you made any provision for long term follow up? I think that would be an important aspect of the study.

Dr. Nyswander: We would like to and it would be extremely important. We are trying to collect data from therapists throughout the city who have had patients. This is a non-financed research project. I finance and I don't know how long I can afford to.

-------: With reference to this question of reliability a recent study was done in Chicago in which families were interviewed and each individual was supplied with an identical questionnaire on major economic conditions. Some omitted children born that year, some omitted reference to a Cadillac. The inaccuracies and failure of the questionnaires from members of the same family to agree were startling. The same problem was encountered in a study of smoking and cancer of the lung. The same may apply to your addicts. They may be motivated to give correct answers and yet not do so completely.

Dr. Nyswander: I have never known an addict to bring up the question of relapse until about two weeks after the relapse. It takes about a year and a half for the addict to bring up painful delinquency.

Dr. Starr: Persons having to do with the law, lawyers, judges, etc., have not infrequently asked me, have you evidence or have you actually heard of an addict who got himself off the drug without being locked up. My impression is that there is very little information on this point in the literature.

Dr. Nyswander: That is really what started me on the project. I wanted to answer that question. There has been informal talk and I know of three papers in the whole literature which state that it can be done; our own experience is confirming it.

Dr. Starr: How many cases would you suppose there are in the literature who got themselves off drugs on their own?

Dr. Nyswander: Three. There are three reports in the whole psychiatric literature and each cites one case.

Dr. Starr: One thing is certain, even if a lot of people got themselves off of drugs the medical profession wouldn't be aware of it at the present time.

Dr. Peterson: I am bothered a bit about the definition of an addict. We are of the opinion that heroin is very addicting and that leads to the belief that anyone who uses heroin is an addict. Yet in the Far East only three percent of those convicted and imprisoned for the use of heroin showed any withdrawal symptoms. There were a lot of week-end users of heroin (sic). Maybe there are two kinds of addicts, the week-enders and those who must have the drug all the time. It could make a considerable difference which kind are in your project, whether the confirmed addict is treatable.

Dr. Kolb: I like the idea that an addict can be treated outside the hospital. I think the young addicts are not very deeply emotionally involved at this stage and you can get promising results. With reference to Dr. Starr's question, I want to say very definitely that addicts do get themselves off drugs on their own, or did when I used to treat addicts. And I don't think you have to assume that all addicts are liars. I have treated doctor addicts. One had been an addict for over 40 years. Pressure was being put on him and he got himself off. Also a couple of psychopathic addicts - we had no reason to believe they were lying - had "cured" themselves without any help at all.

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They had taken themselves off drugs several times, then because of underlying difficulties and adverse conditions would go back to drugs. But they would again and again get off the drug by themselves. Furthermore, the present day addicts don't get much drug; a lot of them could quite easily cure themselves and would do it if the necessity arose; probably some do.

Dr. Yonkman: There seems to be a similarity in the course of addiction and alcoholism. If that is true would Dr. Nyswander be willing to predict that narcotics anonymous might be as successful as alcoholics anonymous?

Dr. Nyswander: Narcotics anonymous in New York is a noble attempt, but I think it is failing miserably. The alcoholic is aggressive; if you ask him his idea of a man, it is one who is rough and tough; that is the alcoholic's idea of what he would like to be. So far as I can see the narcotic addict is not an aggressive. I ask him what he would like to be and his answer is "cool". There is no available aggression for narcotics anonymous. Perhaps Danny Carlson likes to retain authority and in some way is keeping other people from leadership. I don't see any hope in narcotics anonymous, but I support it.

Dr. Starr commended Dr. Nyswander for her attempt to do a very difficult medical job.

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Personal note from Dr. Nyswander, dated February 17, 1956.

"We went over our figures to date and considering that we are not doing any screening whatsoever, they are most encouraging. Of 41 appointments for an initial interview that were made, 35 appeared. Of these 35, 32 agreed to make an appointment with a therapist. Of these 32, 25 kept their first appointment. After four months 16 patients are in active therapy. Of these 16 who are in therapy, 10 were on drugs initially and 6 were off. Of these 10 who were on drugs initially only 4 are still on."