

A CONVERSATION WITH DR. MICHAEL MEASOM

Dr. Michael Measom
Puzzle Pieces of Substance Abuse
(53 minutes)

“A Conversation with Dr. Michael Measom” is a forum bringing together educators, business leaders, concerned citizens, and treatment professionals to discuss issues involved with understanding, treating, and preventing chemical addiction disease. Dr. Measom responds to questions from the audience, providing insights based on his wide-ranging medical training, clinical experience, and professional wisdom.

Dr. Measom talks about addiction as a disease, about recovery and relapse, and about the risk factors which serve as indicators of an individual’s propensity for addiction. He lists the various medications available to help addiction patients, and he describes how they are used.

He notes that the success rates for treatment of those with chemical addiction are about the same as the success rates for treatment of other well-known chronic diseases, including diabetes and hypertension.

Dr. Measom’s informative discussion was organized by the Edward G. Callister Foundation. Other participants included members of a citizens committee called Advocates for Reason about Chemical Addiction Disease (ARCAD), plus invited representatives from state service organizations, local government agencies, volunteer service groups, and professional organizations. The names and titles of participants are listed at the end of the video.

DR. MICHAEL MEASOM is the medical director of the drug and alcohol unit at Valley Mental Health in Salt Lake City, Utah. He is also medical director of AD Psychotherapy and Clinical Services in Sandy, Utah. He was formerly an adjunct associate professor of psychiatry in the Department of Psychiatry at the University of Utah. He has conducted research into the use and mis-use of various medications in the treatment of addiction disease.

Dr. Measom was educated at the University of Utah, where he received a B.A. degree in psychology and an M.D., eventually leading to certification as an addiction psychiatrist.

Chapter 1 – Introduction

Dr. Michael Measom introduces himself, lists his credentials, and explains the difference between an addictionologist and an addiction psychologist..

Chapter 2 – Disease of Addiction

The disease of addiction is similar to diabetes. It is a chronic and relapsing illness. Patients who relapse should be treated the same way as a diabetic whose glucose is elevated,

– as a problem to be corrected.

Addiction, like diabetes, is a lifelong disease. It does not go away. The natural course of addiction is for people to relapse. The key is what you do at the time of relapse.

The brain is the organ used to relate to the world. Any disorder with that organ affects all aspects of an individual's relationship to the world, including biological relationships, psycho-social relationships, and spiritual relationships. Patients talk about having a "void" in their lives.

Many individuals with addiction also experience loss of control, accompanied by compulsive behavior, cravings, and denial.

People continue to use despite adverse consequences, including family disputes, DUI arrests, missing work, and spending time in jail or prison.

Chapter 3 – Recovery (A)

Families and other become frustrated with people who have an addiction. Mental health professionals call it "counter-transference." I tell them people have the right to make a poor decision.

Families should avoid actions which may be perceived as punishing the individual.

It is more effective to approach the individual with love and concern – not just once but again and again.

Recovery requires the development of behaviors that are healthy and that help the individual grow as a person. Developing a healthy lifestyle is part of the psycho-social treatment. Families can help.

Chapter 4 – Loss of Control

It is a myth that everyone must hit the bottom of the curve before they can get better. Many patients have moments of clarity before they reach that point.

Often, primary care physicians don't have enough time with each patient to recognize these moments of clarity and act upon them. It's difficult to do, because addiction is such a complex bio-psycho-social disease.

Patients often report that they lose control of their lives, and that using is an attempt to re-establish control and avoid certain things.

Another manifestation of loss of control is the individual who thinks he or she can take one drink . . . and then ends up having many drinks, leading to serious consequences.

Chapter 5 – Relapse

It is the natural course of the illness to relapse at some point relapse.

It's a complicated issue, because individuals need time to fix things such as interpersonal relationships. But these relationships which need time to fix are the same relationships which may have contributed to the problem. Often, the result is relapse.

We should use relapse as an opportunity to learn and move on to make a change, rather than as one more opportunity to complicate the relationship.

Chapter 6 – Enabling Sources

Families and others can serve as enabling sources for recovery as well as for continued use. A patient told me about his six-year-old daughter bringing him an open can of beer at ten in the morning. Perhaps she did it because she thought it was normal for her father to have a beer. That's the enabling to use part. But it was so shocking to the man that he was motivated to get into treatment. That's the enabling recovery part. I got into this field because I wanted to help human beings improve their lives. It's very rewarding to see patients a year or two later doing very well.

Chapter 7 – Denial

Denial is the most common defense mechanism. They deny having a problem. They deny not only to those who ask, but to themselves as well. A second form of denial is strictly internal. They conveniently “forget” their own experiences and their own commitment to change. That, too, is a form of denial. Since this is a brain disease, it's difficult for the individual to know whether his or her brain is working properly, or whether something else is going on. The question for the therapist is not necessarily whether a patient has stopped drinking, but whether he or she is making progress toward that goal.

Chapter 8 – Frequency/Amount

Frequency of use or amount of use are not reliable measure for deciding whether someone is addicted to alcohol or some other substance. Binge drinkers use heavily but infrequently. That does not mean they don't have addiction disease. On the other hand, I know many people who have a drug or alcohol problem who have not had a drink for ten or twenty years. These drugs affect dopamine release in the brain. Someone may use once, have a powerful reward experience, but never use again for years. If the person remembers that reward experience and thinks about trying to experience it again – chasing the high, they call it – then he or she may be vulnerable to addiction.

Chapter 9 – Lifestyle Changes

It's important to make the changes necessary to succeed with treatment. Maintaining decent interpersonal relationships and decent work relationships is vital. Learning to recognize the cues which make one want to use is an important part of relapse prevention. Watching diet, exercise, and health care on a daily basis is important. Continuing to grow psychologically and spiritually must be part of the lifestyle mix. Medications play a role. We have several medications to help with addiction, but they don't do much good if they are not used as prescribed.

Chapter 10 – Risk Factors (A)

Fifty percent of the risk of developing an alcohol problem is related to genetics. Anxiety or depression are significant risk factors in the psycho-social area. Fifty percent of individuals with an alcohol problem also have an anxiety disorder. Depression and alcohol reinforce one another. People drink because they are depressed, and people are depressed because they drink. It is a complicated issue. Another risk factor is Attention Deficit Disorder (ADD). If it is not treated in adolescence, the risk of developing substance abuse goes up. The use of stimulants to treat ADD creates fear among some individuals, but it actually reduces the risk of addiction and helps them function. The likelihood of abuse of stimulants in that population is actually fairly low. Other risk factors are environmental. They include childhood abuse or neglect, ineffective parenting, chaotic home environment, drug use in the home, and lack of mutual attachments or nurturing. Young people do best in a learning, nurturing environment, where they feel support, where they are able to address their issues, and where they have love, care, and respect.

Chapter 11 – Medications

The biological treatment of addiction is very complicated. Alcoholism is the best example. Three medications for alcoholism are approved by the FDA – naltrexone (ReVia), disulfiram (Antabuse), and acamprosate (Campral). Naltrexone helps with positive reinforcement by reducing the desire for the buzz or the high they receive from alcohol. It strengthens that part of the brain which says don't drink. Campral helps with negative reinforcement, so the urge to return to use is minimized. It weakens that part of the brain which says please drink. Antabuse is primarily a behavioral treatment. It provides one additional motivation for those who want to quit drinking – a commitment not to drink. It works on behavior more than on actual biology. Sometimes, medication is a lifelong treatment. I like to keep patients on Campral or naltrexone at least a year. That gives us time to deal with whatever associated psycho-social-spiritual problems the individual may have. We use anti-depressants for both treatment and prevention. I suspect we will find very similar applications with regard to treatment of addiction. It is important to treat, along with the addiction, whatever underlying problems may exist, including mental health problems, relationships, and physical conditions. Some patients may benefit from using a combination of the medications I have described.

Chapter 12 – Disease vs. Morality

Addiction is not an illness of moral or character attributes; it's a disease. Using to avoid withdrawal or using to seek a repeat of past rewards are common ways to perpetuate addiction. Classical conditioning, where individuals react to learned cues or triggers, is a very common part of addiction disease.

Chapter 13 – Prescription Drugs

I've seen a lot of prescription drug abuse in Salt Lake City, particularly among young males misusing pain pills.

For some, it is "socially acceptable" to go to doctors and get more and more prescriptions . . . and even get medications off the internet.

Certain psychiatric medications are prescribed here more than in other places. That's fine for anti-depressants – because we have a lot of untreated depression – but it's dangerous for medications such as the benzoazaphines like valium.

Chapter 14 – Recovery (B)

Recovery is different for every individual.

Recovery may be defined as achieving the highest level of functioning you possibly can.

It's easy to see where the disease may compromise function, but it is much more difficult to get the individual to the point where he or she wants to make changes. That's the critical first step. It's what we try to accomplish in treatment.

Employers can help by learning to see addiction as a disease. Instead of firing a person for coming to work under the influence, perhaps they could place them in some sort of administrative leave where they're offered treatment.

Ten to fifteen percent of those with alcoholism will eventually commit suicide if they are not treated for addiction disease.

We also need to create parity so that health insurance will pay for treatment. Some pay nothing. Some pay only for de-tox. A few states have passed legislation requiring parity.

With regard to 12-step programs, any sort of psycho-social support is useful, whether it's through a drug and alcohol counselor or a church program.

There is a synergistic and positive effect between support of any kind and the likelihood of success.

Chapter 15 – Risk Factors (B)

These tendencies run from generation to generation because of the genetic predisposition for addiction disease. Studies with twins show that the genetic factor is very strong.

There is a genetic component to Attention Deficit Disorder, also. We see evidence that inappropriate behavior in the classroom tends to run in families, as well.

There is a popular mentality that these people are bad and should be punished. I dare anyone to show me a study where locking them up has worked as well as providing treatment.

The state of Utah has provided some funding to divert people from incarceration into treatment, which has been proven to work.

The challenge is to get people to view it as a disease, and then to treat the whole range of behaviors in addiction and the bio-psycho-social range.

With regard to schools, I see a lot of adults who were missed in school because they were

inattentive rather than hyperactive. The inattentive ones don't get in trouble because they stay below the radar.

There has been a problem for years with incorporating biological treatments with psychosocial treatments. Even some treatment professionals do not believe patients should have medication. My goal is to get people to see it as a disease and offer medical treatment along with other options.

The analogy of diabetes is appropriate once again. We do behavioral treatments, we monitor diets, we send them to dieticians, and they are on medication. A similar model is appropriate for treatment of addiction..

Chapter 16 – Self-esteem Loss

Some mistakenly believe that people who use substances are happy and blissful, but if you meet these people, they are actually in pain.

Self-esteem is important when they are attempting to deal with the pain by seeking treatment. They need a positive self-view, a feeling that they're worthy.

They believe they cannot be happy without substances, when the truth is that they can. Anyone who has been down that road knows they are happier than they were before.

Chapter 17 – Attention Deficit Disorder

ADD appears across all groups of children, including those who are smart, gifted, and talented. Teachers are restricted in what they can say or do with ADD children.

If I were a teacher, I would treat ADD in ways very similar to treating someone with addiction. I would tell parents that I am concerned, that their child has much more potential, and that I would like to help him or her achieve that.

Chapter 18 – Success Rates

When studies look at treatment success, they look six months or twelve months ahead and ask if the person is using or not. Studies don't measure how the person is getting along with their family or how they're doing at work.

Treatment works, but we're not good at measuring it.

Chapter 19 – Treatment Options

Because someone failed in one treatment does not mean he or she is not going to succeed in the future.

We don't always know which treatment will work or which approach will "stick."

Sometimes, we are not fully aware of the influences working on a patient.

Measuring success is a very complicated issue.

Chapter 20 – Age Factors

New studies indicate that drugs may have a different effect on young persons than they do

on more mature individuals. I think that's highly theoretical. It is similar to diabetes or depression. If you don't treat those conditions early, then you have greater problems down the road. With substances of abuse, you can actually cause brain damage or change brain structure. Treatment then requires dealing with those issues as well.

Chapter 21 – Moving Ahead

One analogy might be treating people with head injuries. If you're not aware of that particular issue, then they can be intractable, but if you're aware, you know what to do to help them.

It doesn't mean that they won't respond; it's just a matter of finding the right thing that works for that particular individual in that particular circumstance.

Chapter 22 – Motivation

There is evidence that even forced treatment works.

Where that is impractical, I would say that approaching them with a feeling of care, concern, and love -- showing them you actually care -- rather than being judgmental or punitive, is the most effective approach.

Chapter 23 – Elderly Patients

The unseen, often missed problem with elderly patients is alcohol problems. Primary care physicians often don't think about it.

Twenty percent of the chronic care in the primary care office is related to alcohol.

Alcohol is an aerosolized solvent, like paint thinner. It gets into every system in the body and can cause damage in every system. Some systems are more susceptible than others -- the brain and the liver, for example. But it is often missed.

Chronic use over time can cause problems, as well. It would be advisable to catch those things early on.

Chapter 24 – Summary

Freud, himself, tried to treat alcoholics with analysis and did not have much success, and so for years psychiatrists did not treat alcoholics.

For a long period of time, it was treated by those in primary care.

The measures of success have gotten better and better.

We have become more aware of addiction, and there is much more of it than we were aware of in times past.

For many years, even experts thought beer and wine were okay, and you wouldn't develop an alcohol problem with those substances. We have learned a great deal.

At the same time, the percentage of people who actually get into treatment is limited because there simply is not enough treatment available.

Let's treat addiction. Addiction is a chronic illness. It's no different than diabetes. Let's

help these people.

Chapter 25 – Participants

Members of the discussion group are listed in alphabetical order.

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