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Addiction medicine and addiction psychiatry in America: Commonalities in the medical treatment of addiction

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Abstract

Two competing medical disciplines treat addiction in the United States: addiction medicine and addiction psychiatry. Addiction medicine seeks recognition from the American Board of Medical Specialties whereas addiction psychiatry holds this high-level medical status, a mission that suggests a substantive distinction between addiction medicine physicians and addiction psychiatrists that does not exist. As this article shows, leading addiction medicine physicians and addiction psychiatrists agree on the definition of addiction and that drug treatment is an "art" which requires a multimethod approach. Despite this extensive accord, addiction medicine physicians and addiction psychiatrists draw sharp distinctions between addiction medicine and addiction psychiatry to serve historical, economic, and professional interests, revealing the importance to both disciplines of recognition from the American Board of Medical Specialties and thus jurisdiction over the medical treatment of addiction.

Keywords

United States; addiction treatment; medicine; psychiatry; medical recognition; jurisdiction

Freed (2007) recently identified the widespread but inaccurate belief that most American physicians have expertise on addiction. In actuality, two competing medical disciplines treat addiction in the United States: addiction medicine and addiction psychiatry.

Addiction medicine was born in 1954 when a New York City internist named Ruth Fox, whose husband died an alcoholic, and Marty Mann, the first woman to stay sober with the Alcoholics Anonymous twelve-step program of recovery, founded an organization of physicians interested in alcohol addiction called the New York City Medical Society on Alcoholism. The New York Society promoted the modern concept of alcoholism as an illness that Alcoholics Anonymous invented. Indeed, a number of physicians in the New York Society were themselves recovering alcoholics who turned to Alcoholics Anonymous for care (Freed, 2007; Galanter, 2005), a trend that continued in the 1970s and 1980s as doctors from American medicine's impaired physician movement (see, e.g., Steindler, 1984; Talbott, 1988) and self-described "addictionologists" (doctors in recovery who committed their medical careers to drug treatment) joined physicians with a strictly professional interest in drug abuse to help addiction medicine grow nationally. Today, the leading organization in addiction medicine, the American Society of Addiction Medicine (ASAM), has about 3,000 members, one third of whom are recovering alcoholics and addicts (Freed, 2007).

Addiction psychiatry originated in 1985 when a small group of academic psychiatrists from the American Psychiatric Association founded their own organization of addiction specialists that today, with approximately 1,000 members, is called the American Academy of Addiction Psychiatry (AAAP). The psychiatrists argued that substance dependence was a mental illness which they could treat more effectively than ASAM physicians, especially doctors in recovery whose philosophy of care derived from their personal experience in Alcoholics Anonymous. In 1991, troubled that "within the treatment system, [physicians in recovery] … have supplanted psychiatrists on the front lines" (Group for the Advancement of Psychiatry Committee on Alcoholism and the Addictions, 1991:1292), the psychiatrists used their scholarship on drug abuse, the comorbidity literature that linked addiction and mental illness, and exclusive training programs in addiction psychiatry to persuade the American Board of Medical Specialties, the "gold standard" of physician credentialing, that they possessed specialized knowledge on addiction. Recognition from the American Board of Medical Specialties gave addiction psychiatrists the "right to responsibility" (Goode, 1960) for the medical treatment of addiction, especially since addiction medicine failed to attain comparable professional standing (Freed, 2007).[1]

ASAM still seeks recognition for addiction medicine from the American Board of Medical Specialties (American Society of Addiction Medicine, 2006), a mission that suggests a substantive distinction between addiction medicine physicians and addiction psychiatrists. Similar to the belief that most physicians have expertise on addiction, this notion is also inaccurate. As this article shows, leading addiction medicine physicians and addiction psychiatrists agree on the definition of addiction and that drug treatment is an "art" which requires a multimethod approach. Despite this extensive accord, ASAM physicians and AAAP psychiatrists draw sharp distinctions between addiction medicine and addiction psychiatry to serve historical, economic, and professional interests, revealing the importance to both disciplines of recognition from the American Board of Medical Specialties and thus "jurisdiction" (Abbott, 1988) over the medical treatment of addiction.

Data collection and analysis

Data for this article, part of a larger sociological and historical study on addiction medicine and addiction psychiatry, derive primarily from 17 interviews with addiction medicine physicians, addiction psychiatrists, and doctors certified in both medical disciplines. These physicians created the fields of addiction medicine or addiction psychiatry, occupy or recently held leadership positions in ASAM or AAAP, and influence how other medical professionals and the American public understand addiction and drug treatment. Interview respondents are identified in the article by code: AM = addiction medicine physician; AP =

[1]To be precise, addiction psychiatry is a medical subspecialty under the American Board of Psychiatry and Neurology, one of 24 specialty boards under the aegis of the American Board of Medical Specialties. Also, a full discussion of why addiction medicine has not achieved recognition from the American Board of Medical Specialties is beyond the scope of this article. Suffice it to say that ASAM physicians believe their medical knowledge and experience provide the basis for establishing a new board specialty in addiction medicine. However, recently the American Board of Medical Specialties has resisted recognizing new medical disciplines. Moreover, meetings between ASAM officials and representatives from the American Board of Medical Specialties have produced few tangible results. Some medical professionals have suggested that because addiction medicine physicians come from a variety of medical backgrounds, chief among them general practice, psychiatry, and family and internal medicine, their original fields of practice should create an addiction medicine subspecialty. This idea, along with the effect of ASAM's tradition of physicians in recovery on medical specialty status for addiction medicine, requires further research.

addiction psychiatrist; and AM/AP = physician certified in addiction medicine and addiction psychiatry. The number adjacent to respondents indicates the order in which they were interviewed.

Interview respondents were selected with a variant of purposive sampling called “expert sampling.” Expert sampling involves the recruitment of respondents who have specialized knowledge about a particular field or subject matter (Trochim, 2001). Interview respondents were recruited based on the following criteria: 1) their role in the development of addiction medicine or addiction psychiatry; 2) their clinical or scholarly contribution to the medical treatment of addiction; and 3) their current or former administrative position in ASAM or AAAP. These recruitment criteria emerged from a review of the medical literature on addiction treatment, examinations of ASAM and AAAP’s administrative structure, and respondent recommendations.

Eleven interview respondents are former presidents of ASAM or AAAP, and most respondents direct or consult drug treatment centers or hospital recovery programs as well as run private medical practices. The addiction medicine physicians reported training backgrounds in general medicine, internal medicine, neurology, pharmacology, and cardiology. The addiction psychiatrists—including four doctors certified in both addiction medicine and addiction psychiatry whose professional loyalties lean toward ASAM—are certified in general psychiatry by the American Board of Medical Specialties. Six interview respondents reported that they are in recovery from addiction.

Fifteen interviews were conducted by telephone to accommodate respondent work schedules and geographic distance. Face-to-face interviews are typical, but telephone interviews provide equally valid data (see, e.g., Smith, 2005; Sturges & Hanrahan, 2004). Each interview was semistructured, approximately 90 minutes, and tape-recorded. The interview protocol consisted of 15 questions on the medical background of respondents, the concept of addiction and addiction treatment, and professional distinctions between addiction medicine and addiction psychiatry. The informed consent form that each interview respondent signed did not guarantee confidentiality and was approved by the Committee for the Protection of Human Subjects at The Graduate Center, The City University of New York. Medical texts on addiction and substance dependence, in particular the third edition of *Principles of Addiction Medicine* (Graham, Schultz, Mayo-Smith, Ries, & Wilford, 2003) and the revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), supplement the interviews.

Data were analyzed inductively using the grounded theory method (see Glaser & Strauss, 1967, 2006). Each interview was transcribed and imported into Atlas.ti, a qualitative data analysis program that is used across the academic disciplines (see, e.g., Barry, 1998; Gibbs, 2007). The interview transcripts were then analyzed to identify and code text on “definitions of addiction” and “addiction treatment,” or how ASAM physicians and AAAP psychiatrists define and treat addiction, including claims from both groups of doctors regarding how the fields of addiction medicine and addiction psychiatry care for addicted patients. In conjunction with a review of how addiction medicine and addiction psychiatry originated and developed, specifically examinations of coded text on medical specialization, medical

training, professional competition, recovery, and specialty recognition, each interview transcript was reanalyzed to identify additional phrases, sentences, and paragraphs that corresponded to two comprehensive codes, “addiction” and “treatment approach,” which represented the full range of responses to how addiction medicine physicians and addiction psychiatrists define and treat addiction and differentiate between their respective disciplines. Alongside medical information on addiction and substance dependence from *Principles of Addiction Medicine* and the *Diagnostic and Statistical Manual of Mental Disorders*, data suggest that ASAM physicians and AAAP psychiatrists draw sharp distinctions between addiction medicine and addiction psychiatry to serve occupational interests and not clinical objectives.

Defining addiction: Conceptual accord

In the 1990s, “brain mechanisms [had] … become a major focus of addiction research, and addiction research [had] become a major focus of modern neuroscience” (Wise, 2000:27). Alan I. Leshner (1999), for instance, former director of the National Institute on Drug Abuse, America’s top addiction research center, noted that science knows more about drugs and the brain than about most other ways the brain works. Addiction, Leshner stated, is a chronic disease triggered by the effect of compulsive drug abuse on the brain. Specifically, “a metaphorical switch in the brain seems to be thrown. … Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction, characterized by compulsive drug seeking and use” (Leshner, 1997:46).[2]

In 2001, ASAM crafted a definition of addiction that borrowed from Leshner’s brain metaphor. Appearing in the third edition of *Principles of Addiction Medicine*, ASAM’s main clinical text, the definition reads that “[addiction is] a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: “impaired control over drug use, compulsive use, continued use despite harm, and craving” (Graham et al.. 2003:1601–1602).

Addiction medicine physicians echoed ASAM’s definition of addiction as a brain disease. “Taking a drug on a regular basis … will change the way your brain behaves,” said a former president of ASAM. “Once that change has taken place, your ability to control your intake of that drug begins to deteriorate” (AM-5). One of the field’s most vocal leaders agreed. “If you abuse [drugs] and have a genetic template, you will get changes in the [brain] which lead to compulsivity” (AM-11). Another ASAM member called addiction a “brain disorder” that causes uncontrollable drug use “in spite of the consequences” (AM-2). Adding to these descriptions, an ASAM physician with 30 years of treatment experience argued that “chemical dependency is a chronic brain disease characterized by regular use of mind-

[2]Addiction has not always been called a brain disease. In fact, the concept of addiction as a brain disease was as much an ideological victory benefiting addiction medicine and addiction psychiatry as it was a clinical and scientific “discovery.” For the first time, medical professionals who studied and treated addiction could identify the condition’s exact location. Addiction was no longer simply a physical “allergy” with unknown origins as Alcoholics Anonymous suggested or the product of unconscious thoughts and a problematic childhood as Freudian psychoanalysts proposed.

altering drugs, continued use of those drugs in spite of adverse consequences, … increased use over time, withdrawal, … and a tremendous compulsion to continue using" (AM-4).

The word "addiction" is not included in the revised fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*), American psychiatry's official analytic text. Instead, the phrase "substance dependence" refers to "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior" (American Psychiatric Association, 2000:192). The diagnosis of substance dependence is based on experiencing at least three of seven clinical criteria in a one year period: 1) tolerance; 2) withdrawal; 3) heavy drug use over an extended time period; 4) uncontrolled use; 5) effort and time finding drugs, using them, and recuperating after use; and 6) reluctance to participate in normal life events. The seventh criterion of substance dependence only tenuously ties drug use with mental illness: "the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is *likely* [emphasis added] to have been caused or exacerbated by the substance" (American Psychiatric Association, 2000:197). The *DSM-IV-TR* also lists "substance abuse" which, unlike "dependence," does not involve physical tolerance, withdrawal, and compulsive use (American Psychiatric Association, 2000).

"Formally, I would define addiction the way dependency is defined in *DSM-IV*," said a nationally recognized AAAP psychiatrist (AP-9). "Addiction [is] … the equivalent of … [the] *DSM* diagnostic criteria for dependence," a colleague stated (AP-7). A former president of AAAP concurred. "Addiction means that a person has acquired a dependency on a chemical [and is] defined in *DSM-IV*" (AP-8). Informally, however, the psychiatrists described addiction similarly to how ASAM doctors did, even though the psychiatrists used the word "dependency." One of AAAP's founders stated that "addiction … usually involves … physiological dependence, tolerance, withdrawal, … problems with stopping use, [and] compulsivity" (AP-7). Another psychiatrist noted that addiction is an "overwhelming involvement with the … use of a drug and severe dependency on it … [that has] gotten significantly in the way of important aspects of life" (AP-9). A former head of AAAP said that "addiction … means a person has acquired a dependency on a chemical that … shapes their thinking, their behavior, and their motivational effort" (AP-8). Finally, a psychiatrist who has studied substance abuse for 40 years stated that "addiction is the use and dependence of addictive substances to the extent that it begins to interfere in important aspects of an individual's life. [Addicts] … attempt to control their use, but they continue to use despite the adverse consequences" (AP-12).

One treatment expert declared that terminology leaves addiction medicine and addiction psychiatry in "a hell of a fix" (AM/AP-16). Physicians from both fields use words such as "addiction," "substance dependence," "substance abuse," and "chemical dependency" interchangeably. Conceptual uncertainty, said an addiction psychiatrist, comes with the job:

> The likelihood that anyone has … the psychiatrically defined disease of "substance abuse" is almost zero. Of my patients, probably 95 percent … have dependence or

> addiction, and the other 5 percent have something else [but] none have "[substance] abuse" … Other doctors … say, "most of my patients have [substance] abuse. I must be seeing a … different group of people than Dr. [X] is." Probably not. If we swapped places my percentages would be the same. It's just a matter of definition (AP-21).

Indeed, drug treatment terminology in addiction medicine and addiction psychiatry is historically unstable. In the mid-1970s, as addiction medicine was organizing under the American Medical Society on Alcoholism, ASAM's precursor, the field defined alcoholism but not chronic drug use (see National Council on Alcoholism/American Medical Society on Alcoholism Committee on Definitions, 1976). In the early 1990s, ASAM published a definition of alcoholism that is remarkably similar to its current definition of addiction (see Morse & Flavin, 1992)—a definition that itself significantly changed between the first and third editions of *Principles of Addiction Medicine* (see Graham & Schultz, 1998; Graham et al., 2003; Miller, 1994). In the *DSM-I* and the *DSM-II*, printed in 1952 and 1968, respectively, psychiatry distinguished between "alcoholism" and "drug addiction" (see American Psychiatric Association, 1952) and then between "episodic excessive drinking," "habitual excessive drinking," "alcohol addiction," "other [and unspecified] alcoholism," and "drug dependence" (see American Psychiatric Association, 1968). Since 1980, psychiatry has used the term "substance dependence" (see American Psychiatric Association, 1980) while today some psychiatrists argue that "addiction" should replace "substance dependence" in the forthcoming *DSM-V* (see O'Brien, Volkow, & Li, 2006).

In fact, a close look at ASAM's definition of "addiction" and *DSM-IV-TR* "substance dependence" reveals that both terms link the brain, behavior, and biology to chronic drug use. For the brain, ASAM chooses the term "neurobiologic" while psychiatry uses "cognitive." To describe the development of behavior, ASAM refers to "psychosocial" and the psychiatrists to "behavioral." For addiction's biological component, ASAM uses the word "genetic" but psychiatry prefers "physiological." ASAM states that these factors lead to "craving" and "impaired control" despite "harm." In the *DSM-IV-TR* the above "symptoms" lead to "withdrawal" and "compulsive" use despite "substance-related problems." Lastly, although a link between chronic drug use and mental illness is one criterion for substance dependence, that diagnosis is not contingent on a psychiatric problem.

ASAM physicians and addiction psychiatrists also similarly described "addiction." ASAM doctors argued that addiction is a brain disease that leads to uncontrollable drug use despite adverse consequences. Although the psychiatrists seldom used the words "brain" and "disease" when they talked about drug "dependency," they referred to the same physiological symptoms (e.g., impaired control, compulsivity, and withdrawal) and adverse consequences of habitual drug use. One addiction specialist concluded that "inside the world of psychiatry and inside the world of addiction medicine … there is considerable consensus about [addiction's] biological basis" (AM/AP-22). Psychiatrists and the *DSM-IV* have been "strongly influenced" by ASAM's definition of addiction, said a doctor who straddles both fields, "although they would never acknowledge it" (AM/AP-19).

Treating addiction: Methodological accord

Addiction medicine physicians and addiction psychiatrists agreed that the medical treatment of addiction requires a multimethod approach based on the clinical needs of each patient. The treatment methods to which they referred included cognitive behavioral therapy, group therapy, medications, individual psychotherapy, and twelve-step programs. Cognitive behavioral therapy modifies the "core beliefs" of addictive behavior and helps patients develop coping strategies to avoid relapse (Beck, Liese, & Najavits, 2005). Group therapy addresses aspects of recovery related to physical and mental health, lifestyle choices, and family and professional issues (Daley, Mercer, & Spotts, 2003). Medications decrease substance use or the intensity and duration of drug effects while psychotherapy focuses on the emotional problems that contribute to drug abuse (Rounsaville & Carroll, 2003). Finally, Alcoholics Anonymous (AA) is the "prototypical organization" of the twelve-step genre (Galanter, Hayden, Castaneda, & Franco, 2005:511).

An ASAM physician who wants a pill that can "change the changes" in the addict's central nervous system is resigned to "work with what pharmacological agents we have and use cognitive behavior therapy. … [We also] try to encourage people to go to [twelve-step] groups because … [addiction] is a chronic illness and the medical system isn't going to pay for repeat episodes of cognitive behavioral therapy" (AM-5). Another ASAM doctor follows a "multidirectional" approach. "I do not argue with the principles of AA in which [addiction] is a psycho-social-physiological-spiritual disease. [But] … now with some of the newer medications coming out and … newer techniques of looking at the brain, … I think there are definitely additional ways of treating [addiction]" (AM-2). The most effective way to treat addiction is with a multidisciplinary team, concluded a prominent ASAM member. "I'm … very opposed to looking at addiction without psychiatric input, but I'm also opposed to … treating this disease … just through a psychiatric window" (AM-11). A colleague concurred. "You have to approach everyone individually [because] … they come to you in different stages [of] this disease. Some have been using regularly … for 35 years, some for two years, [and] some don't even know they have any trouble yet" (AM-4).

A nationally recognized addiction psychiatrist said that "twelve-step approaches are very helpful, [as are] cognitive behavioral approaches [and] psychodynamic approaches. So really trying to tailor the treatment to the patient in addition to the fact that we have some new psychopharmacological agents" (AP-7). A former president of AAAP noted that "we've got … different methodologies. … Specificity is what makes treatment work. If I have a broken arm, I don't need insulin. One size fits all [is] a bad idea" (AP-14). Another psychiatrist argued that the primary methods to treat addiction are "all good at different times for different people … You need to deal with psychiatric … factors and the Twelve Steps can be invaluable" (AP-9).

Indeed, AAAP psychiatrists did not discount twelve-step programs such as AA despite originally organizing in response to ASAM physicians who advocated twelve-step programs professionally, used them personally, and, as examined below, despite accusing addiction medicine physicians of relying almost exclusively on twelve-step treatment due to ASAM's tradition of physicians in recovery. According to one mental health professional,

psychiatrists "respect and understand the twelve-step approach just as well as [ASAM doctors] would" (AP-8). Another psychiatrist argued that the AA "recovery culture" is psychologically effective:

> I say to my patients, "I want you to go to [an] … ongoing residential program or [a] day treatment program so that you can get introduced to the recovery culture." [That] is the AA tradition. They [addicts] have to have the safety net. I can't provide them [a] "24/7" safety net, but that tradition can. So it's not only practical [and] useful, but it's a very germane paradigm. I think AA works because it's an extraordinarily sophisticated group psychological approach (AP-12).

A colleague in psychiatry agreed. "The purpose of [AA] meetings is … to make it so you learn how to interrelate with others so that you have a way of relieving the … anxiety that is a normal part of the human condition. … It [AA] doesn't get rid of the fact that you have a chronic illness, but it certainly makes it so that now you can deal and cope with it" (AP-21). According to another addiction psychiatrist, "by far, the most effective program for maintaining abstinence from chemicals is the twelve-step approach. I strongly encourage all my patients to attend AA … or another variation on the theme" (AM/AP-17). "I can tell you that if I were stuck with only one treatment," said a former president of AAAP, "it would be twelve-step" (AP-20).

The "art" of addiction treatment

That ASAM physicians and AAAP psychiatrists agree on the value of twelve-step groups yet handle addiction based on the clinical needs of each patient shows the complexity of drug treatment. And here again addiction medicine physicians and addiction psychiatrists agree. "Unfortunately, there's a great deal of art in this game," said one AAAP psychiatrist. "Often you're taking a shot at [treatment] based on your intuition, but you don't even know if you're right because the [research] studies are so difficult to do … and so lacking. … So there is some art here" (AP-9). One ASAM physician compared American medicine's knowledge about addiction to its knowledge about infectious disease. "I believe to talk about a cure [for addiction] in the way that we found … [cures for] infectious diseases, I think we're a long way from that. I think we'll keep describing it, … but I doubt there's going to be a single answer to all of this" (AM-11). The National Institute on Drug Abuse promotes addiction as a brain disease, noted one mental health professional, "and that implies that you need scanning, medicine, and psychiatrists. But the truth is scanning hasn't shown anything in psychiatry except pretty pictures" (AP-9).

"I think we're dealing with the fact that a lot of medicine is a combination of science and craft, and that's especially true in addiction psychiatry," said one of the founders of AAAP. "A lot of things aren't that well researched out and a lot of people do things on the basis of the way they were trained and what their experience was" (AP-7). This assessment applies to ASAM's definition of addiction as well as *DSM-IV-TR* substance dependence. "These are evolving concepts, nothing is written in stone, and I had something to do with helping write and consult on the *DSM-IV*. … Not everything is absolutely crystal clear [or] scientifically proven" (AP-7). A former president of ASAM concurred. "I give groups … to patients and they always ask me what chemical dependency is. I show them three circles: all the people

in America who don't use [drugs], all the people who use [drugs] occasionally, … and other people who use [drugs] and get a disease. People really can get that. I wonder … whether we in medicine get it" (AM-4). One treatment expert replied. "I think we're still at the level of humors, as in [Greek physician] Galen. The truth is we know a lot about medicines. … We know a lot about comorbids. We've … worked with the Twelve Steps. … We're learning" (AP-9).

Treating addiction: Disciplinary discord

Despite considerable accord on how to define addiction and approach the "art" of drug treatment, ASAM physicians and AAAP psychiatrists drew sharp distinctions between addiction medicine and addiction psychiatry. With an ASAM physician, "you [the addict] are going to … get a full physical exam. … You'll be prodded and poked. Bloods will be drawn. There will be an approach [from] the perspective of whole body issues." In contrast, addiction psychiatrists prod and poke for behavioral and psychological issues. "You're not going to get undressed. You're not going to have your labs drawn" (AP-21). Addiction psychiatrists "make a comprehensive list of psychiatric diagnoses … the substance use disorder being one of them," concluded one treatment expert, "and addiction medicine physicians are interested in providing a list of all diagnoses and looking at a variety of medical complications" (AM/AP-16). Addiction psychiatry "truly does honor … the psychodynamic traditions of understanding that human psychological problems are not … chance happenings and developments," stated one of AAAP's most respected members. Conversely, "non-psychiatrists probably would be more inclined to keep [treatment] simple and to try and stick to the basics of getting the addiction under control" (AP-12).

An ASAM physician who believes psychiatrists are less patient with addicts compared to addiction medicine doctors doubted this assessment. "[Psychiatrists] look at motivation and willingness to change … before they're willing to work with somebody. In medicine you … don't get to say, 'you're not motivated [to change] so I won't see you'. … You try and help them [addicts] as if it [addiction] [was] a health issue instead of … a behavioral issue" (AM-4). Another expert concurred: "the psychiatrists … diagnose comorbidity and medicate whereas I think addiction medicine doctors are much more patient in terms of seeing how the individual looks sober" (AM/AP-22).

Comparing these differences to a "religious war," one AAAP psychiatrist said "there's a lot of ASAM doctors … who have … good skills, but … they don't know anything compared to [us] about psychopharmacology … or diagnosing comorbid disorders" (AP-9). Stated differently by another psychiatrist, "most of those [ASAM] guys are not all that sophisticated … [because they] … have no behavioral health training, which means they don't know anything about psychotherapy, … the therapeutic alliance, … [or] cognitive behavioral therapy" (AP-14). According to three former presidents of AAAP, "if you're talking about the knowledge set of psychiatrists, I think [we] have a broader array of diagnostic … and treatment approaches that [we're] trained in" (AP-12). Moreover, "how these things get applied in psychiatry … [are] at a different level than in most areas of medicine" (AP-7). Consequently, "some of the leadership of ASAM has been hostile to psychiatry, … [because] they [have] got to know … we know more than they do. … We

paint with more brushes in more colors and have a wider skill-set than they do. It's just that simple" (AP-14).

In response, one leader of ASAM said that "addiction psychiatrists generally loathe to venture into the internal medicine or primary care world because of their own lack of training. … It's more likely that an addiction psychiatrist will consult to get the medical needs of their patient met than you'll see addiction medicine physicians consulting a psychiatrist" (AM/AP-16). Similarly, another ASAM member asked: "I need to be a psychiatrist to give somebody methadone? I need to be a psychiatrist to treat overdose? I need to be a psychiatrist to detoxify people" (AM-10)? Probably not, said a AAAP psychiatrist, but "I don't know any ASAM [physician] … that mustn't have a lot of exposure to comorbidity issues. … It would be malpractice almost. But maybe not. Maybe … there are some purebreds out there and they still insist it [addiction] is a disease" (AP-12).

This statement is telling. Although AAAP psychiatrists endorsed twelve-step programs such as AA that promote the disease concept of addiction, they also used twelve-step programs to distinguish addiction psychiatry from addiction medicine. In other words, addiction psychiatrists support twelve-step programs claiming to have selected from several treatment methods they are trained to administer. As one psychiatrist said, compared to ASAM physicians, addiction psychiatrists "need not have such a profound belief system" (AP-9):

> ASAM is much more … dominated by recovering people … who often can relate to the profound spiritual issues that exist in people who are doing drugs. … The psychiatrists can look at a bunch of modalities, including the Twelve Steps, and recognize the appropriateness of all of them. … ASAM is more based on the Twelve Steps and sees the other [methods] as more peripheral, though it's changing (AP-9).

Indeed, addiction psychiatrists conceded that twelve-step treatment in addiction medicine is declining, but they still identified addiction medicine with the AA twelve-step approach. One psychiatrist divided ASAM physicians into two groups. The first group advocates "nothing else but the twelve-step program, and you better join that church and follow it to the letter of the law." The second group is "tuned in to detoxification, maybe some medications … and a little counseling, but they'll still be very twelve-step oriented" (AP-8).

The twelve-step "mentality" in ASAM and addiction medicine is still "hugely, hugely pervasive," claimed another addiction psychiatrist. Therefore, "you get a lot of people with a lot of attitude who sound like a bunch of jerks these days because what they're saying isn't 'evidence-based.'[3] It's belief based—'it's my way or the highway [and] this is the only way to recover.' A lot of those people can't think of … somebody recovering without twelve-step, without AA. And that's ridiculous." This psychiatrist sends "the bulk" of his patients to AA. "But do I think one size fits all? It's like a religion. It's like 'there but through me you're not going to get to God.' I think that is presumptuous, arrogant, and plainly wrong" (AP-14).

[3]Simply stated, evidence-based medicine emphasizes systematic medical research over clinical experience. This paradigm currently penetrates almost every corner of American medicine, not just the medical treatment of addiction.

A former president of ASAM, himself a recovering addict, noted that "everything I say is … evidence-based because I've been the brunt of [this type of criticism]" (AM-15). Another physician in recovery considers his personal history of alcoholism as valuable therapeutically as evidence-based medicine. "Who we are is so inseparable from our transactions from others. This bears on … epistemology. … My colleagues who … dismiss that are … ignorant of those questions" (AM/AP-22). This doctor attributed contempt for his "therapeutic use of self" to his contemporaries' fixation on evidence-based research (see, e.g., Project MATCH Research Group 1997; COMBINE Study Research Group 2006). "My colleagues, particularly in psychiatry, have this thinly veiled antagonism. [They] won't seriously look at a question unless they can use … 'evidence-based research.' And there is a malignant side to that. There is an intellectual … arrogance in that that's just really sad" (AM/AP-22).

Medical jurisdiction: Recognition from the American Board of Medical Specialties

ASAM's definition of "addiction" and *DSM-IV-TR* "substance dependence" both link the brain, behavior, and biology to chronic drug use. Additionally, both terms, and the doctors who used them, identify impaired control, withdrawal, craving, and adverse consequences of drug abuse. Addiction medicine physicians and addiction psychiatrists agreed that drug treatment is an "art" that requires a multimethod approach including behavioral and group therapies, medications, and twelve-step programs such as AA. Despite this extensive accord, ASAM physicians and AAAP psychiatrists drew sharp distinctions between addiction medicine and addiction psychiatry. ASAM physicians argued that addiction medicine's emphasis on the medical complications and emotional needs of addicts is equally if not more effective than addiction psychiatry's concern with comorbidity and behavioral issues. Conversely, the psychiatrists claimed that their discipline's knowledge of the mental health components of substance abuse and behavioral interventions exceeds addiction medicine's reliance on twelve-step care.

Why do ASAM physicians and AAAP psychiatrists agree on how to define and treat addiction yet clash over the medical and psychiatric principles that should guide addiction treatment? The explanation is partly historical. Since at least the early twentieth century, physicians who treat addiction have not been highly regarded. Colleagues in other medical fields believed that addiction treatment wasted time and resources while the public saw drug abuse as a moral problem which the church should handle (Block, 1959; Johnson, 1973). The medical treatment of addiction has been called "dirty medicine" (Josiah Macy, Jr. Foundation, 1973:2) and today drug treatment providers from all medical backgrounds are "not immune from the same stigma that has tracked addiction problems in patients" (Pichot, Starck, Harris, & Benzick, 1997:¶7). Therefore, in defense of their respective efforts to accumulate at least enough collegial and public esteem to create and sustain what they claim are fundamentally different medical disciplines—as Goode (1960) says, to legitimize their own "charter"—ASAM physicians and AAAP psychiatrists draw sharp distinctions between addiction medicine and addiction psychiatry even though they agree on what addiction is and how to treat it.

Another part of the explanation is economic, specifically the impact of America's system of managed care on the medical treatment of addiction. Funding for drug treatment mostly derives from federal programs such as Medicaid and from state and local agencies. This trend is likely to continue (Levit et al., 2008). However, addiction medicine physicians and addiction psychiatrists agree that for substance abuse patients with private insurance, managed care has reduced the type and frequency of treatment they can receive (see, e.g., Galanter, Keller, Dermatis, & Egelko, 2001; Mechanic, Schlesinger, & McAlpine, 1995; Schoenbaum, Zhang, & Sturm, 1998). As a result, managed care arguably pushes these addicts, who are likely ineligible for publicly funded care, to use free and available services such as twelve-step programs like AA. As one physician already quoted put it, "[we] try to encourage people to go to [twelve-step] groups because … the medical system isn't going to pay for repeat episodes of … [treatment]" (AM-5). In fact, AA is the most utilized type of addiction care (Substance Abuse and Mental Health Services Administration, 2008). To protect their economic interests, then, ASAM physicians and AAAP psychiatrists need to convince a small pool of potential patients—those whose private insurance plans cover at least some substance abuse treatment who do not exclusively attend twelve-step programs—that their disciplinary approach to drug treatment is the most effective.

But one more explanation links the historical and economic reasons why ASAM physicians and AAAP psychiatrists agree on how to define and treat addiction yet clash over disciplinary distinctions. This explanation speaks to winning both collegial and public esteem *and* patients as well as underscores the plain difference between addiction medicine and addiction psychiatry: "jurisdiction" (Abbott, 1988), or professional power, over the medical treatment of addiction as embodied by recognition from the American Board of Medical Specialties, "widely recognized by physicians, healthcare institutions, insurers and patients themselves as an essential tool to judge that a physician has the knowledge, experience and skills for providing quality healthcare within a given specialty" (American Board of Medical Specialties, n.d.).

To reiterate, addiction medicine still seeks jurisdiction over the medical treatment of addiction in the form of recognition from the American Board of Medical Specialties. The criticism by ASAM physicians that addiction psychiatry misses important medical (i.e., physical health) complications of drug abuse by focusing on psychological issues, behavior, and motivation to change is meant to expose the limitations of the psychiatric approach to treatment and, furthermore, to argue that the addiction medicine approach deserves recognition from the American Board of Medical Specialties. However, revealing the contrast between professional objectives and clinical practice, or the "occupational usages" of knowledge compared to "technical expertise" (Freidson, 1970:357), ASAM physicians are "very opposed" to treating drug abuse "*without* [emphasis added] psychiatric input" (AM-11), argue that their understanding of psychiatric comorbidity is sufficient to provide "a list of *all* [emphasis added] diagnoses" (AM/AP-16), and maintain that "you have to approach [addicts] individually" (AM-4), including, presumably, those who require strict psychiatric care.

"Jurisdiction is a more-or-less exclusive claim. One profession's jurisdiction preempts another's" (Abbott, 1988:34). Addiction psychiatrists seek to defend the jurisdiction over

addiction treatment that they won in 1991 from the American Board of Medical Specialties. They compare their discipline's treatment approach, legitimized and codified by evidence-based research, with claims that addiction medicine is unsophisticated and ignores scientific evidence due to its twelve-step "mentality" (AP-14) and tradition of physicians in recovery. But again demonstrating the variance between occupational and clinical objectives, addiction psychiatrists concede that "on the biological side [of addiction treatment], they [ASAM physicians] may be more sophisticated" (AP-7), "strongly encourage" (AM/AP-17) all of their patients to join a twelve-step program, send "the bulk" (AP-14) of their patients to AA to "deal and cope with" alcoholism (AP-21), and if forced to choose one treatment, "it would be twelve-step" (AP-20). To repeat one nationally recognized addiction psychiatrist, "I think AA works because it's an extraordinarily sophisticated group psychological approach" (AP-12).

The discipline that eventually wins the competition between addiction medicine and addiction psychiatry might ultimately shape the medical treatment of addiction. Until then, this competition underscores how specialized knowledge generates claims to professional power (Abbott, 1988). Despite substantial accord among ASAM physicians and AAAP psychiatrists over how to define addiction and approach the "art" of drug treatment, both groups of doctors claim to have specialized knowledge that warrants jurisdiction over the medical treatment of addiction. These claims might be the chief commonality between addiction medicine physicians and addiction psychiatrists.

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