ALCOHOL & DRUGS

MODERN SOCIAL CURSES

AN ARTICLE REPRINT SERIES

ALCOHOLISM— The Road to Recovery

Alcoholism is a worldwide problem especially in advanced nations, but it is also a problem for which the mode and level of treatment is common to most nations. On May 8, 1976, 52 prominent people met in Washington, D.C., to announce to the press and the world: "We are recovered alcoholics." Dubbed "Operation Understanding," the media event was sponsored by the National Council on Alcoholism to dispel the myth that alcoholism doesn't happen to "nice" people and to reduce the moral stigma that cripples efforts to successfully treat the disease. "Operation Understanding" also underscored the fact that people can recover from alcoholism and that there are resources and agencies that can help alcoholics resume—or enjoy for the first time—normal, happy, successful lives without alcohol. To find out what resources exist on a local level to help the alcoholic achieve sobriety, we sent a contributing editor into the community of Pasadena, California. Here is his report.

While 500,000 alcoholics in Southern California were making the rounds of the bars, careening in cars on the freeways, or nursing their bottles at home on the evening of August 25, 1976, 200 plus happy, grateful, recovered alcoholics were celebrating the 35th anniversary of the South Pasadena-San Marino chapter of Alcoholics Anonymous and their own sobriety. They were a living testimony that alcoholism can be overcome.

Alcoholics Anonymous is the most successful modality of treatment for alcoholism in existence today. It began in 1935 when two alcoholics discovered they could strengthen their sobriety by sharing their experiences and helping others suffering from alcoholism. Today AA has grown to 22,000 local chapters in 92 countries. An estimated one million people participate in AA—more than found in all other modalities of treatment combined.

AA Steps and Traditions. On the flyleaf of their literature AA describes itself "a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism." AA is nonsectarian and nonpolitical. It neither endorses nor opposes any causes.

The key to the individual alcoholic's success are the "Twelve Steps" of AA, and the key to AA's success as an organization is its "Twelve Traditions."

The "Twelve Steps" read at the start of every AA meeting, starts as follows:

- We admitted we were powerless over alcohol—that our lives had become unmanageable.
- Came to believe that a Power greater than ourselves could restore us to sanity.
- Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
- Made a searching and fearless moral inventory of ourselves.

The "Twelve Traditions" that govern the fellowship as a whole include such points as:

- The only requirement for AA membership is a desire to stop drinking.
- An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise.
- Every AA group ought to be fully self-supporting, declining outside contributions.
- Alcoholics Anonymous should remain forever nonprofessional but our service centers may employ special workers.
- Anonymity is the spiritual foundation of our traditions, ever reminding us to place principles before personalities. (In respect of that tradition, only initials or pseudonyms of alcoholics are used in this article.)

The Payoff—Sobriety. The fruits of AA's approach to alcoholism were everywhere in evidence at the 35th anniversary celebration. It was evident in the happy smiles, the warm handshakes, the camaraderie, and the concern that pervaded the room.

It was evident from the number of "birthdays" being observed. "Birthdays" in AA are the date of a member's last drink. Each complete year of sobriety is celebrated with a "birthday cake." That evening 13 people observed from 1 to 30 years of complete sobriety. It was evident in the reactions and words of those who

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came forward to blow out the candles on their cakes.

The "babe" of the celebrants, a middle-aged woman, B. G., was marking her first year of sobriety. After hugging her sponsor (the person who helped and encouraged her to attend AA) and blowing out her candle, she turned to the audience and began, "I'm a *very* grateful alcoholic . . ." but could not finish for the tears of joy.

A middle-aged man. S. H., celebrating 5 years of sobriety, said with profound emotion, "If I could have written a scenario five years ago, I couldn't have imagined all the good things that have happened to me since I achieved sobriety."

The last of the celebrants was a wealthy businessman. T. P., with 30 years of sobriety. A dozen of his children and grandchildren were there for the occasion and applauded with special vigor. He asked, "How can you express what it is like to have 10,959 days of sobriety after experiencing 20 years of alcoholic living death?"

Help That Goes Begging. In the United States, an estimated one out of every ten drinkers is an alcoholic. That adds up to over nine million people of all ages for whom one drink is too many and a thousand is never enough.

In Britain there is a minimum of five hundred thousand alcoholics, but it must be remembered that for virtually every alcoholic there are several other sufferers—wives, husbands, children, parents, friends, employers.

Pasadena has its share—14,000 by one estimate. Only a small fraction of them have sobered up, but it has not been for lack of opportunity or help. Pasadena has a wide variety of agencies and programs to help the alcoholic. "There's help running out of the ears," says Jean B. Vandervoot, executive director of the Pasadena Council on Alcoholism. But alcoholism is a disease of denial. Most alcoholics will not admit to themselves, let alone anyone else, that they have a drinking problem.

Consequently, it is very difficult to help most alcoholics until they have sunk into their own personal hell. Alcoholics must often suffer broken marriages, lost jobs, jail sentences, auto accidents, cirrhosis of the liver, delirium tremens, and other crises before they run out of alibis and seek help.

"Referral and educational services such as ours can help people to avoid going to the bottom," says Jean. "People don't have to lose loved ones or jobs. If they're informed and if they get treatment and help in the middle part of their disease, they can save themselves from all that suffering."

The Turn of the Tide. In spite of the readily available help, a certain percentage do hit the bottom of bottoms—the late or chronic phase where obsessive drinking results in physical complications and imminent death. For these people, recovery must begin at one of the two detoxification centers in Pasadena: Pasadena Community Hospital or St. Luke Hospital.

Similar 'drying out' centers exist in most major cities in America and Europe.

On the wall in the corridor of the detoxification ward of Pasadena Community Hospital hangs a poster with a message and metaphor. The message is: "The lowest ebb is the turn of the tide." The metaphor is a turbulent surf crashing on the rocks of a rugged coastline.

The poster states a fact and presents a hope for the alcoholic. The fact is his health, his very life, is on the rocks. Alcohol has devastated his personal life and is literally killing him. He has come or been referred to the "detox unit" "to dry out" under medical supervision because it's too dangerous to do so on his own.

The hope is that they *can* bottom out and rebound. Most alcoholics who seek help do recover and go on to lead productive, happy lives.

While touring the detox facility at Pasadena Community Hospital, a call came from the front desk: An alcoholic man wanted to be admitted. Staff counselor Bill Rose went to see him. At the age of 27, Bill is a veteran, an expert on drug abuse, having spent over half his life—14 years—as an addict-alcoholic, a multiple drug user. Now he's part of the solution instead of the problem. He has been "clean" for a year and started working in the detox unit a couple of months ago.

Bill brought back a dishevelled, 40-year-old man — the kind of alcoholic stereotyped in jokes and TV comedy skits. But this real-life alcoholic was no laughing matter, rather a sick man named Larry.

Larry said he had been drinking half a gallon of vodka over the past couple of days. Now he was "tapering off" with wine to avoid delirium tremens. He had them once before several years ago and doesn't want to experience the agony again. He had also been hallucinating. The paperwork was begun, and Larry started detoxification and a 21-day rehabilitation program which consists of two vital parts: occupational therapy and group therapy.

Small But Important Steps. Jerrie Williams, occupational therapist in the detox unit, gave me a tour of the occupational therapy room. It is small and simply equipped and contains supplies for painting, knitting, and macrame. In another room there is some exercise equipment for those who want a little more vigorous activity.

As plain and simple as some of the materials and tasks are, they have important therapeutic benefits. The first steps toward recovery must necessarily be small and often undramatic.

All alcoholics are losers in some sense, and some are complete losers—people who have never succeeded, never accomplished anything in their life. Learning to perform rudimentary tasks in occupational therapy can provide positive reinforcement that enables them to tackle bigger tasks and problems of everyday living.

A Rebirth. The heart and core of every rehabilitation program is group therapy. Here the alcoholic faces the reality of himself—his problems, needs and aspirations. He also faces the reality of other people who, he often discovers, are cut from the same fragile, imperfect cloth.

"We try to improve their self-image. In the deepest part of their being, alcoholics don't like themselves. They feel very inferior," says George Richardson, another staff counselor. "By getting everyone to come out from behind his shield, each alcoholic learns that he isn't any different from anyone else. This

helps him to accept others and cope with anger, resentment, and frustration rather than drink."

The detox unit at St. Luke Hospital across town is larger and the program somewhat different. But it too is a benign assault on a losing, destructive life-style. While being detoxified at St. Luke Hospital, the alcoholic patient is evaluated for the following 21-day program designed to help him clean up—and dry up—his act and get a new and winning show on the road. As Bob C., a recovered alcoholic, put it, "Sobriety is the tip of the iceberg. What is involved is a brand new life, a new beginning. If I may say so, a rebirth."

Sean Hamilton, community services coordinator for St. Luke's detox unit, explained that "we evaluate every aspect of the patient's life physically, psychologically, socially, and even spiritually. Each patient is given a complete physical, not only to diagnose alcohol-related diseases but any other ailments he may have. We have physical therapy for those who need it. If the alcoholic has problems with his job, we bring in the employer. If he is dissatisfied with his job, we interview him for vocational rehabilitation.

"Families, friends, employers—anyone connected with the alcoholic—are brought in to help confront the patient with his problem as well as be a part in his recovery."

In addition, St. Luke Hospital has established an out patient program to help the alcoholic stay dry in a wet world. "But no one can do the entire job alone," stresses Hank Klein, chief alcoholic therapist at St. Luke Hospital. "We cooperate with other agencies. We tie the alcoholic's recovery into the community-based resources."

Recovery Homes. The first community resource that alcoholics are exposed to is AA. The second is often the recovery home, the half-way house on the road to sustained sobriety. Pasadena has three: the Grandview Foundation, the Bishop Gooden Home, and La Casa (for women). The setup and program varies from home to home, but each provides a minimum of three to four weeks of refuge and rehabilitation.

The Bishop Gooden Home primarily serves the white-collar worker, the professional man, and the prosperous businessman. In contrast, The Grandview Foundation has a more heterogeneous group including the unskilled, the indigent, and the welfare case. Three or four weeks may not suffice for many of the less fortunate, so a relatively new nonresidential program has been developed to provide needy alcoholics with 10 to 15 months of counsel and help. "We feel that the alcoholic needs to be involved for at least a year in rehab programs—AA, group therapy, etc.—to be able to say he has put his act together. That is the bare minimum necessary to stabilize fairly well his sobriety," states James Panariello, program director for Grandview.

But even then relapses are possible and that is why regular attendance at AA is the best guarantee of happy sobriety. A number of authorities believe it takes three to five years of total sobriety to say an alcoholic is truly stable and recovered.

La Casa, established in 1968, is something of a rarity in alcohol rehabilitation—a facility exclusively for women. In Britain there is a similar center at Spelthorne St. Mary in Hertfordshire. "If only they had something like this back in New York City, I might have recovered sooner," lamented E.M., a recovered alcoholic.

"But they don't because women alcoholics aren't as visible as men alcoholics. I just stayed home all day and drank. Anytime I needed some more, I just got on the phone and said, 'Send over a case.' "

And then, without prompting, she gave a bout by bout account of her drinking career: (Be forewarned! Ask a recovered alcoholic a simple question, and you may get a ten-minute autobiographical sketch. Their candor is amazing—and refreshing.) "It finally got so bad that I was rushed to the hospital vomiting up blood. My temperature was 106°. I needed nine blood transfusions. I stayed in the hospital for two weeks living on jello.

"The day I got out, I walked around the corner and bought a bottle. I still had further to go to reach the gutter.

"I finally ended up in the psychiatric ward in Bellevue . . . In a moment of clarity, I said to myself, 'You're in trouble. Do exactly what they say.' I did and got out. But I never licked my problem until I came west and discovered La Casa."

Carrot and Stick. "Whereas in many countries the drunken driver is treated purely as a criminal, in Pasadena he is treated as a sick person, and for him there is a special route to recovery. First-time offenders are referred to four, weekly 2½-hour educational and rap sessions on alcohol abuse and available recovery programs. First-time offenders are motivated by the carrot of a reduced fine for successfully completing the program or the stick of the full fine for not attending.

Multiple offenders are referred to the High Road Program. The High Road Program provides a minimum of 12 months for the education and resocialization of the chronic alcohol and other drug abuser. The goal is the revamping of the drug offender's life-style.

"The rate of recovery or life change is phenomenal," reports Robert Dorris, project director of the

A SPIRITUAL "POINT OF NO RETURN"?

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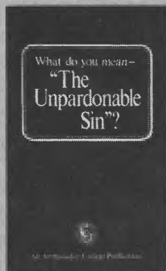

High Road Program. "We're seeing 80% to 90% of the participants make a basic change. The length of the problem is a big key to its success. We don't claim to have more information—just more time for people to understand and absorb it."

Helen Dorris, personnel director for the program, points out another factor that is lacking in most other programs: The carrot and stick motivation provided by the courts gives alcoholics an added incentive to comply with the program. Failure to do so could mean no reduction in charges or legal penalties, and they are much more serious for multiple offenders.

Cooperation and Care. A recent development in Pasadena is the formation of a coalition of agencies and programs dealing with alcoholism in the city which could serve as an example for other areas and nations where cooperation is usually of a looser nature. "This had been done before in name, but until now not in fact," states Charles M. "Buz" Hamilton, assistant executive director of the Pasadena Council on Alcoholism. "We strive to assist each other and keep the focus on helping the alcoholics in Pasadena."

"Oh there are some internal squabbles," admits Sean Hamilton, "But we're all working for the same goal. We all realize we need cooperation—not competition."

This spirit of cooperation is but a manifestation of a factor that all the diverse programs and agencies have in common—that great intangible called love, care, concern. Those three words cropped up again and again as I talked with recovered alcoholics and those involved in rehabilitation. "You don't have to have a degree to help alcoholics," declared Colleen Cervik, who supervises the Pasadena Community Hospital detox unit. "But it does take care. People who care, who are dedicated to helping others, make all the difference in an alcohol recovery program."

Epilogue: After writing the story I called Bill Rose and asked him about Larry. "Funny you should ask," he replied. "I just saw him a while ago. He's up at Grandview, and is attending group therapy and AA. He's coming along fine." □

Can an Alcoholic Ever Resume Drinking?

For nearly two decades there has been a smouldering controversy over whether an alcoholic can ever resume "normal drinking." On June 9, 1976, it burst into flames with the release of a report on alcoholism by the Rand Corporation, Santa Monica, California.

The report suggested that some alcoholics can, after treatment, resume normal drinking without risking a relapse.

The researchers emphasized in their report that they were not recommending that alcoholics resume drinking. They agreed that there are alcoholics who cannot drink without getting into serious trouble but added that there is no way to tell in advance who they are.

The conclusions of the report were controversial enough; unfortunately, the news media exacerbated the issue by giving the story such alarming headlines as "Study Suggests Alcoholic, Treated, Can Drink Safely," despite the cautionary notes given in the report. The result was angry criticism from scores of researchers and paraprofessionals in the field of alcoholism. Many expressed the fear that the report's conclusions and the way the media reported them would endanger the lives of some alcoholics by encouraging them to resume drinking.

On July 1, the National Council on Alcoholism sponsored a press conference in Washington, D.C., in which eleven widely respected researchers in the field of alcoholism rebutted the Rand report. Some of the weaknesses in methodology they cited were:

(1) All data were based on the clients' self-reports of the quantity of alcohol consumed, with no objective verification, such as blood samples to determine alcohol concentration.

(2) The actual number of patients interviewed was too small a percentage of the original number of alcoholics being investigated. Six months after treatment, researchers were able to locate only 20.6% of the 11,500 patients they originally included in the survey. After 18 months they were able to locate only 62% of the 2,161 designated to be surveyed.

Combining the 6- and 18-month studies, over 70% of the patients weren't interviewed. Dr. David Pittman has shown the harder an alcoholic is to locate for follow-up interviews, the more severe his problem with alcohol is likely to be.

(3) The reporting period of 18 months is too short a time to decide that "normal drinkers" will not relapse. Dr. John Ewing, director of the Center for Alcohol Studies at the University of North Carolina, conducted a study for controlled drinking over a period of over 55 months. He found that "the results looked promising in the first 12 to 18 months. It was only when we did a long-term follow-up ranging from 27 to 55 months since treatment ended that we detected a universal failure to maintain controlled drinking."

(4) The maximum amount of alcohol consumption considered by Rand to be "normal" is considered by others to be excessive.

The Rand report is not the first report to suggest that some alcoholics may resume drinking. And a couple of new reports have been released since the Rand report making similar conclusions. But most people working with alcoholics would emphatically agree with Dr. Jokichi Takamine, chairman of the American Medical Association Committee on Alcoholism: "Abstinence must remain the foundation of recovery for the alcoholic." Indeed, since its inception over forty years ago, AA has never found one alcoholic who could resume social drinking. To put it simply, alcoholics shouldn't drink alcohol.

***Freddy C. was a well-known entertainer whose career and family life were nearly destroyed by his addiction to alcohol. Since overcoming the problem, he has recently had a book published, entitled* The Alcohol Problem Explained.**

by Freddy C.

The year 1954 was, to quote a phrase, a vintage one. I was considered one of the top musicians in Britain. I was married to a wife with whom I was very much in love, and I had two lovely daughters. It seemed nothing could possibly go wrong.

My work consisted of accompanying all the big "names" in the world of films, recordings, and TV. I was on first-name terms with all those artists. This was not only good for my bankbook but also my ego.

But if I had position, money, and family life, I also had one other thing that just cannot be left out of this little saga—alcohol. And if the truth must be told, I was quite happy with the arrangement. For alcohol is unique. Its properties are remarkable: If you are cold, it will create the feeling of warmth; if you are warm, it will bring the illusion of coolness. If you are tired, it will provide instant energy; if you are tense, it will act as an instant relaxer. Not for nothing has it been called Nature's Anesthetic, and for those who can handle the stuff, it has at times proved a blessing.

But I couldn't handle it. And people who can't handle it shouldn't drink it. But when the exacting and demanding work started to bring mental pressures, I found that a glass of Scotch brought not only instant relief but also a confidence that was needed to do a particular job. And so the bottle became as necessary a part of my equipment as was my instrument.

A person who drinks for reasons other than social is on a dangerous path, and I was no exception. The price that had to be paid for my booze slowly crept up. Rows, tears, and scenes with my wife and girls were commonplace.

The one-time dependable character who used to sit in the orchestra with "nerves of steel" was slowly reduced to a nervous, shaky, pathetic character whose only nerves were those of alcohol.

"Try and control your drinking," friends advised. "Use a bit of willpower," they declared. "Pull yourself together," they suggested. I just couldn't get through to them that I WAS trying to control the stuff; I WAS trying to use my willpower.

What I did not know is that alcohol, to the alcoholic, is the greatest destroyer of the will; and when the will has gone, so has the control. And when the control has gone, the alcoholic is in no position to pull himself or herself together. Once the first drink has gone down, the mental obsession coupled with the physical compulsion makes the alcoholic a slave to alcohol.

WITH A FRIEND LIKE ALCOHOL, WHO NEEDS ENEMIES?

And so the job, money, family, and everything else that I had so desperately tried to hold on to started to go. What was I to do? First of all I went to see the family doctor. "How can I help you?" he asked.

"It's my nerves," I answered truthfully. After all, they were in a terrible state. So he treated me for nerves, and things got worse. He sent me to a psychiatrist (I was to visit eight in all), and he, too, asked me the problem. This time I mentioned that I drank a little too much, but only because of the pressure of work, plus the fact that I now suffered from insomnia and amnesia.

He treated me for tension, nerves, insomnia, and amnesia, and I continued to drink and continued to suffer from nerves, tension, insomnia, and amnesia. It was as vicious a circle as one could imagine, and I couldn't get out of it. I tried hypnotists, faith healers, and health farms, but the end result was that I woke up in a police cell and then was moved to a locked ward in an alcoholic unit. It was here that they did the impossible: They stopped me from drinking.

But I subsequently learned that the alcoholic's main problem is not only to STOP drinking, but also to STAY stopped. After being released from the unit, I began drinking almost immediately. In sheer desperation I phoned Alcoholics Anonymous, and the same night I attended my first meeting.

I just could not see how the well-dressed and seemingly happy people there could in any way be identified with the shivering mess that was me. But the minute the speaker opened his mouth, I knew that I was in the right place. He talked my language. One reason AA is so successful is because when a shy, embarrassed alcoholic walks into their meeting, no one laughs, condemns, or ridicules him, because all of them, without exception, were in similar shape when they themselves began attending. It is that personal identification that contributes to the success of AA. All have been in exactly the same boat—or bar—as the newcomer. And as soon as the new member feels THAT kind of identification, they are on the first rung of the ladder back to sobriety and sanity.

But just to stop drinking alcohol is not enough in the treatment for the illness of alcoholism; the alcoholic must not only stop *drinking* alcohol, he must also stop *thinking* alcohol. The thought precedes the action: If he thinks it, he will drink it.

Alcohol is unique, and so is alcoholism. And to combat alcoholism, there has to be something equally unique—the Fellowship of Alcoholics Anonymous. The number of the nearest AA group is in your phone book. Dial now if you need help.

Chances are better than fifty-fifty that you know someone who drinks too much. The National Council on Alcoholism estimates that at least one out of every ten people who drink in the United States suffers from the disease of alcoholism. That fact translates into ten million alcoholics!

And less than five percent of them are on skid row. The other 95-plus percent have "skid row between the ears," but otherwise live and work at all levels of society. They are bankers, corporate executives, politicians, truck drivers, teachers, secretaries and housewives. They are your friends, your fellow workers, members of your family.

And when one is a close friend, relative or mate, you suffer right along with the alcoholic. It isn't true that people with drinking problems hurt only themselves. Experience shows that at least four other persons are affected by the behavior of a problem drinker. He can't keep his problem contained within himself. It extends to his family, friends, fellow workers, and employers.

What can you do? First, realize that the situation is not hopeless. People can recover from alcoholism. Effective help is available. The excellent program of Alcoholics Anonymous, for example, is available in hundreds of communities from coast to coast. AA claims its program has helped over one million people achieve sobriety.

Here are some dos and don'ts to effectively deal with a problem drinker and steer him toward a recovery program.

IF SOMEONE YOU KNOW DRINKS TOO MUCH

DO

• Learn about the disease of alcoholism and how to recognize the symptoms by reading the literature printed by health agencies. Alcoholism is a complex, progressive disorder that involves a physical and psychological dependence (addiction) on the drug alochol. The alcoholic can't stop drinking once he's started, even though alcohol is destroying his life. Unless the nonalcoholic person understands the nature of the disease, he cannot deal effectively with a person suffering from it.

Most people know little or nothing about alcoholism. And what they think they "know" is probably mostly made up of myths and misconceptions. (Two excellent information agencies on alcoholism in the United States are the National Council on Alcoholism, 733 Third Ave., New York, New York 10017 and the National Clearinghouse for Alcohol Information, Box 2345, Rockville, Maryland 20852).

• Learn about the resources in your community for dealing with alcoholism. Ignorance of the resources available to treat the disease is as great as ignorance of the disease itself. Visit an alcoholic treatment center or an open meeting of Alcoholics Anonymous, a fellowship of men and women who help each other maintain their sobriety. Look into Al-Anon, an organization which deals with the problems of those who live with alcoholics. (In recent years more and more experts have come to realize that alcoholism cannot be treated as if it involved the alcoholic alone. It is a family disease and successful therapy must involve the entire family.)

Discuss the situation with someone you trust—a clergyman, social worker, a friend—preferably someone who has experienced alcoholism personally or as a family member.

Remain calm, and be factually honest in speaking with the problem drinker about his behavior.

• Let the problem drinker know you are reading and learning about alcoholism. Let him know where he can go for help.

• Establish and maintain a healthy atmosphere at home, and try to include the alcoholic member in family life.

• Explain the nature of alcoholism to the children involved.

• Encourage new interests and participate in activities that the alcoholic person enjoys—except drinking, of course.

• Be patient. Live one day at a time. Alcoholism generally develops over a period of years. It can't be cured overnight. Expect and accept setbacks with perseverance and calmness.

DON'T

• Attempt to punish, threaten, bribe, cajole or preach. Guard against "holier-than-thou" or martyrlike attitudes.

• Lose your temper and thereby destroy any possibility of helping.

• Allow your anxiety to compel you to try to do what the alcoholic can only do for himself.

• Cover up or make excuses for the alcoholic person or shield him from the consequences of his behavior.

• Hide or dump bottles, or shelter the problem drinker from situations where alcohol is present. Such measures are self-defeating. Remember, the alcoholic is addicted to alcohol, and one way or another he will obtain the drug he craves.

• Argue with an alcoholic when he is drunk.

• Drink along with the problem drinker.

• Ride with the alcoholic person if he insists on drinking and driving. Drinking drivers are responsible for 800,000 auto crashes and the slaughter of over 28,000 lives in the United States each year.

• Accept guilt for another's behavior.

In short, don't ignore the problem or be afraid to be involved. Do learn about alcoholism, guide the drinker to help, and support him in his battle with the bottle.

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DRUGS — Who Needs Them?

The primary problem with drugs is not what they do, nor who uses them—but why people abuse them. Until we can answer the why, drug abuse among teenagers—and adults—is here to stay. Drugs are not the problem—but symptoms of other problems.

In many respects, the current drug scene is a replay of the forbidden-fruit scene in the Garden of Eden.

You know the story. "Did God say, 'You shall not eat of any tree of the garden'?" said the serpent (Satan) for openers. Every tree is all right to eat, replied Eve dutifully, except the tree of the knowledge of good and evil, which would be fatal.

Then the serpent gave the come-on: "You will *not* die. For God knows that when you eat of it your eyes will be opened, and you will be like God, knowing good and evil."

It worked. "So when the woman saw that the tree was *good* for food, and that it was a *delight to the eyes*, and that the tree was to be desired to *make one wise*, she took of its fruit and ate; and she also gave some to her husband, and he ate" (Gen. 3:1-7). The rest is history.

The Modern Forbidden Fruit. Today's forbidden fruit for teenagers are the psychoactive drugs: marijuana, LSD, mescaline, barbiturates and amphetamines, and the opiates. Millions of young people find the temptation to try them at least once to be irresistible. And they are truly a mixed bag of good and evil: all of them can be used for legitimate medical purposes—but they also can be used in ways that can destroy health and happiness. Many who have tried the harder drugs have "surely" died.

But, of course, our analogy with the tree is not complete. For this chemical tree of the knowledge of good and evil does not grow in a 20th-century Garden of Eden. It flourishes in a world that is turning into a man-made hell. For many people, psychoactive drugs have become a means of pursuing paradises in the mind (or at least escaping a ho-hum or hapless existence).

So the circumstances have changed — but people have not. What motivated Adam and Eve to try the forbidden fruit also motivates teenagers to try drugs today.

Fun—A Neurological Necessity. "It was a delight to the eyes" goes the official account. In other words, the tree was very pleasing to the senses.

Likewise, psychoactive drugs can be a delight to the eyes—and the ears, and the nose, and the taste buds. They enhance, they alter, the stimuli coming to the brain from the five senses. These novel sensations and perceptions are considered to be fun, and they constitute one of the primary reasons people play with these chemicals.

Now for some Basic Psychology 101. Everybody likes to experience fun, joy and pleasure. We like to be entertained and amused. We like to experience new and pleasant sights, sounds and tastes.

But "like" is not really the word. Pleasure, good times, enjoyable stimuli are more than superfluities or luxuries in life — they are necessary to life itself. Considerable research indicates that stimulation through the five senses is one of the primary needs of higher organisms.

Stimulus hunger is a basic motivation. Enjoyable stimuli are sought and preferred, but if only the unpleasant or uninteresting stimuli are available, the brain will settle for what it can get rather than shrivel up. The brain survives in such cases, but mental health suffers.

That stimulus hunger is a compelling, life-sustaining need can be seen in the following experiments.

Variety—The Very Stuff of Life. In one experiment, researchers analyzed the effect of boredom. College students were paid to don padding and blindfolds and lie on beds in isolated rooms so that sensory stimuli—sight, sound, touch—were reduced to a minimum. What remained was extremely monotonous.

As time dragged on, students became irritable, restless, unable to concentrate. They talked to themselves, whistled, sang, recited poetry, counted numbers—anything to relieve the boredom. Eventually the boredom made it impossible for some to think, and they just let their minds drift. And to the surprise of the researchers (they discounted the reports until they went through the test themselves) many of the students after long periods of isolation began to hallucinate.

Of Rats and Men. If the mind has an aversion to boredom, it really tunes in and turns on to abundant pleasurable stimuli. This was demonstrated in an experiment where scientists implanted electrodes into the pleasure centers of rats' brains. They placed the rats in test boxes that had a treadle. By pressing it, the rats received a very mild electrical shock to their brains. To get another stimulus, the treadle had to be released and pressed again.

The rats "turned on" to the electric stimulus test—literally. Rats with electrodes planted in the hypothalamus — which mediates diges-

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tive, sexual and excretory processes—went into electrical ecstasy. They stimulated themselves from 500 to 5000 times per hour. Some stimulated their brains more than 2000 times per hour for 24 consecutive hours! So rewarding was this stimulation that the rats forsook all external pleasures, food, water, sex, everything — to trip on the treadle.

Human beings aren't rats. But at times they feel as if they are treated like rats, and they speak of dropping out of the "rat race." In the mid-sixties a lot of them — mostly teenagers — did just that. They turned on with LSD and other drugs that provided a direct connection to their brains, intensifying sensory experiences. And they turned on with other "electrodes" such as STP and speed. These drug binges often lasted for days—so new and powerful was the experience.

"Desired to Make One Wise." Of course, human brains are much larger, human cognitive processes much more complex, than rat brains. People have higher and more varied needs and motivations. Man does not live by bread and circuses alone. He is also motivated by concerns for security, love, self-esteem, identity, self-fulfillment and a sense of meaning and purpose to his life.

Drugs were a means of protesting a "system" that deprived people of these other basic needs. More than a negative protest, drugs were also viewed by many as a positive means of constructing new values and lifestyles to supplant the old.

For drugs did more than titillate and entertain. They could alter consciousness and change the way people thought and looked at the world and themselves. They could open up new vistas of understanding and knowledge. Like the tree in the midst of Eden, drugs were "to be desired to make one wise."

Altered Consciousness. Consciousness is one of those phenomena that occurs but is not easy to define. Very simply stated, it is the total mental configuration of a person, his perception of reality. It is the sum total of this thoughts, moods, perceptions—all the mental processes and modes of which he can be aware.

Whatever consciousness is, many parents are sure they don't want it altered. Since the words "altered consciousness" are commonly used in connection with drugs, they suffer from guilt by association. Actually, the words are quite innocent, because altered consciousness is something all of us—whether we use drugs or not—experience every day!

Sleep, drowsiness, daydreaming and meditation are all different states of consciousness. We shift back and forth through these states in the course of our daily activity. We can even chart some of these states with an electroencephalograph—an instrument that measures brain waves.

So altered consciousness is a common everyday occurrence. In addition, society condones—even encourages via commercials and advertisements—the deliberate alteration of consciousness by drugs! People take barbiturates to sleep, alcohol to relax, and amphetamines or caffeine (coffee) to stay awake. Parents who dread their children using mind-altering drugs such as pot may be using two or three mind-altering drugs themselves—all the while wondering what their kids see in drugs.

What their children see are images and colors unlike anything experienced in the usual states of consciousness or in the mild states of altered consciousness parents induce by means of over-the-counter drugs and alcohol. In these "higher" states of consciousness, spatial relationships and the sense of time are dramatically changed. Thinking becomes nonlinear and free flowing. Sensations ebb and flow in intensity. The experience can't really be described in words, drug users say, anymore than you can verbally describe sunlight to a person born blind. A person must see and feel it for himself to comprehend what it is all about.

Dreams Become Nightmares. Because drugs put things into a whole new perspective, it was deemed in the early days of the Youthquake to be an excellent catalyst for revolution, creativity, personal growth, mystical experiences—whatever the drug user's intellectual bag was.

Unfortunately, drugs carry no guarantees of good trips or new revelations. Many people who were inexperienced and apprehensive about drugs had anything but ideal experiences. Cases of toxic psychosis, permanent psychosis and panic reactions were widely reported in the late 60s.

And worse yet, drugs alter body chemistry as well as consciousness. No psychoactive drug is perfectly safe. None is free of potential health hazards. All have undesirable side effects. No matter how high the experience, sooner or later the drug user must come back to earth and experience the side effects and consequences of a particular drug. Some side effects and post-trip symptoms are mild, and long-term damage is slight or unknown. But the harder drugs—the opiates, the barbituates and amphetamines—can enslave the user by the tolerance and dependence syndrome. Certain doses and combinations can kill.

But the full dangers of drugs, particularly the harder drugs, weren't widely known then. Or they weren't *believed* since the information came from people over 30 who were just using nonfactual scare tactics. (That

DRUGS: the good, the bad, and the deadly

From booze to hash, from caffeine to heroin, mind-altering drugs have become a way of life. Nearly everyone needs a "fix"—for pleasure, for escape, or just to keep going. If you'd like to know more about drug use, its benefits and dangers, write for *The Dilemma of Drugs*. It's free. Mailing addresses are on the back cover.

was true—to a point.) Even when the mounting death toll made believers out of skeptics, some continued to use them undeterred by the dangers. It seemed as if they had some kind of script that called for them to be chemical kamikazes.

The summer of love in '67 soon turned into a winter of discontent and disillusionment. A lot of chemical dreams turned into nightmares. Speed killed; heroin enslaved. Barbiturates enslaved and killed. By the hundreds they killed.

The Drug Illusion. Those who took drugs for spiritual and philosophical reasons largely avoided the harder drugs and their hazards, preferring instead softer drugs such as LSD and marijuana. They were looking for new ways to live—not die. But a funny thing has happened over the years: Many of these seekers of truth and meaning have dropped drugs altogether! Why? Because they finally pierced the great illusion of drugs and came face to face with the reality: they didn't need drugs to enjoy life. They didn't even need them to explore their consciousness.

That drugs are the best or the only way to explore consciousness is the greatest misconception held by many drug users. In truth, there are many ways of altering consciousness *without* drugs. Various esoteric disciplines have been demonstrating how for centuries. Biofeedback has shown promise as a modern technique.

Many people who have tried both drug and nondrug methods of consciousness alteration prefer the latter – no hassle with unpleasant distracting side effects during the experience and no post-letdowns or depressions afterwards. They discovered they were flying high in coach with drugs — when all along they could have gone first-class without them.

Something Better. Because of the health hazards, and because a lot of idealistic users have gone on to other things, drugs are no longer sugarcoated with high expectations and naïve ideology. But millions of teenagers are still taking them. A lot of teenage drug use is—always has been—experimental. Curiosity, and peer pressure, entices them to try a drug once or twice. It's part of growing up—a modern rite of passage, it seems.

But a significant minority continue to use drugs over and over for reasons other than because "it's the thing to do." For them, drugs are a chemical substitute that stands in for whatever is missing in their lives, a buffer from whatever bothers them. Drugs provide stimulation when there is nothing else stimulating to do. They bring relief from the unpleasant stimuli of life—the problems and anxieties. They are a dramatic way to kill time—and maybe kill oneself if nothing else worthwhile shows up.

The philosophy, the approach to life of many a drug abuser, is summed up in this conversation:

Interviewer: "Why do you use drugs?"

User: "Why not?"

Interviewer: "How could someone convince you to stop?"

User: "Show me something better."

The Carrot or the Stick? "Basically, individuals do not stop using drugs until they discover 'something better,' " believes Dr. Allan Cohen, widely recognized expert on drug use. "The key to meeting problems of drug abuse is to focus on the 'something better' and maximize opportunities for experiencing satisfying nonchemical alternatives."

Basic Psychology 101 again: The carrot will bring about more effective and longer-lasting change than the stick. People respond more constructively to positive inducements and rewards than to negative deterrents and punishments.

For example, if a person is motivated to use drugs for physical satisfaction or relaxation, he may be profitably directed toward physical activities—sports, dancing, hiking, carpentry. If he is seeking sensory stimulation, he may find more satisfying experiences with sensory awareness training, music, or developing an appreciation for the beauty of nature.

The alternatives model is practical because it is based on the premise that there is no one cause and hence no one sure solution for everyone. It tailors programs to fit people, not people to conform to programs. It allows the person the freedom and opportunity to discover and develop his full potential.

This approach works because it treats the drug problem for what it really is—a people problem. It shifts the focus from what drugs do to *why* people use them. As such, it is not only effective in getting people off drugs, but also in *preventing* them from getting started.

And prevention is the ultimate solution to drug abuse. But that will require a radical overhaul of our way of life.

For the drug problem is more than a threat to our way of life—it is the tragic *result*. A society that offers "something better" than drugs is a society that will not be afflicted by drug abuse to the extent we find today. The continuing high level of drug abuse means that a lot of young people need—but don't have—something better to do.

Tree of Life. Back in Eden there was a positive alternative to the tree of the knowledge of good and evil. That was the tree of life—symbolizing God's revelation, guidance and instruction. It was readily and freely available. But the original parents believed the original con artist rather than the Creator. Their children have fallen for the same line; they have eaten the same bitter fruit ever since. Mankind got off on the wrong foot, and each generation has perpetuated the same errors in thinking and choosing. The result has been a steady narrowing of options for optimal living and a proliferation and compounding of mistakes and problems.

It may seem ridiculous to say that today's drug problem—let alone all our problems—can be traced back progressively to that fatal choice in Eden—but that is the etiology of today's sad state of affairs.

Someday, soon, Christ will return to set things right. Then Satan, the Great Deceiver, will be put out of commission (Rev. 20:2-3), and Christ, ruling over and working with man, will build a world where people matter, where God's way will prevail.

Even now the tree of life is available to all who want a real choice in life, a real chance to realize their God-ordained potential. What that potential is, and what you can do about it *now*, are explained in our free booklets *Why Were You Born?* and *Just What Do You Mean—Conversion?* Be sure to write for them. □

THE COCAINE-CRAZE

The ancient Incas considered the plant from which it was taken to be divine. An early twentieth-century German user exclaimed: "God is a substance!" And a contemporary American user said of its effect: "You feel like Adam, and God is blowing life into your nostrils."

The divine drug so ardently revered is cocaine, one of nature's most powerful stimulants. Used and venerated by the Andean Indians for 3,000 years, cocaine has acquired hundreds of thousands of modern devotees in North America and Europe in the last few years. It has fostered a billion-dollar industry in the black market of illicit drugs.

Status Drug. Cocaine is often called the "marijuana of the rich" or the "champagne of drugs." This is because the well-to-do are often the only ones who can afford to buy it illegally at champagne prices of $1,000 to $2,000 an ounce. (Hospitals and pharmacies can buy the drug legally as an anesthetic for $31.50 an ounce—which gives an idea of the possible profits on the black market.) To be able to distribute the drug gratis among friends at social occasions is thought to be a sure sign of success; the chic way to flaunt one's affluence is to proffer the coke for inhaling (a "snort") through a tightly rolled $100 bill.

The drug so desired among today's decadent rich is derived from the leaves of the coca bush, grown principally in the uplands of Bolivia and Peru. For centuries the Indians of the Andean regions in South America have chewed the leaf for the stimulant and appetite-depressant effects that facilitate heavy labor and long treks.

Some writers compare the consumption of cocaine in this form to the Western habit of drinking coffee (which contains the stimulant drug caffeine) to stay alert. The amount of drug found in both products is small (1.6 to 2.5 percent caffeine in Latin American coffee; .65 to 1.25 percent cocaine in coca). Because of such low levels of concentration, chewing the coca leaf is not considered a "dangerous drug abuse" by many drug experts, although both the Bolivian and Peruvian governments have tried to cut consumption in their countries—with little success.

Freud and the Cocaine Papers. Cocaine became a problem drug after it was isolated and concentrated from the leaf, a feat accomplished in 1865 by the German physician Albert Niemann. In 1844 Sigmund Freud read about the use of cocaine to increase the stamina of some Bavarian soldiers during training maneuvers. He promptly procured a supply of the drug for experiments on patients and himself. There followed a flurry of papers on his use of cocaine to treat morphine dependence, depression and fatigue. Freud termed these reports a "Song of Praise"—so high was his initial opinion of the drug.

But his rapturous relationship with the drug soon soured. True, cocaine didn't build significant tolerance. (That is, it didn't require escalating doses with regular usage to achieve the same high as did morphine.) And it didn't lead to excruciating withdrawal symptoms (as did morphine). But Freud, and other contemporaries working with the drug, observed that a strong psychic dependence often developed in many users. The drug's high only lasted 15 to 20 minutes, after which the user sank back into a depressed state—a state which now seemed worse when contrasted to the fleeting drug-induced high. This strongly motivated him to repeat the dose frequently to restore the euphoria. Repeated doses eventually led to toxic psychosis—hallucinations, paranoia, etc. Prolonged snorting also resulted in deterioration of the mucuous membranes and septum.

Freud published his last defense of the drug in July 1887 and shortly thereafter discontinued use of the drug personally and professionally. Though he never developed a dependence for cocaine, it is said he had to undergo three operations to repair the damage to his nose.

"The Real Thing." The research into cocaine by Freud and others contributed to a small boom in the pseudo-medical and nonmedicinal use of the drug at the close of the nineteenth century. Makers of patent medicines quickly jumped on the bandwagon and concocted scores of potions containing the drug. Cocaine was the "real thing" in Coca-Cola until 1903. A wine containing coca extract, called "Vin Mariana," was heartily drunk and endorsed by such notables as Pope Leo XIII, President William McKinley, Anatole France and Thomas Edison. "On a per capita basis, cocaine used in America in the mid-1890s was considerably greater than it is today because it was found in the cola drink, was the first remedy for hay fever and seemed like one of the miracle drugs," says Dr. David F. Musto, associate professor of psychiatry and history at Yale.

But cocaine was rapidly acquiring a bad name, and in 1922 the U.S. Congress prohibited most importation of coca leaves and cocaine, thus driving it underground. The act also destroyed legitimate medical research on the drug. Consequently, a deficiency of knowledge about the drug exists to this day. "The medical and scientific community have appallingly little information [today] about the effects of cocaine," lament Lester Grinspoon and James B. Bakalar, coauthors of a new book on the drug, *Cocaine: A Drug and Its Social Evolution.* "The clinical literature is sparse, and mostly more than 50 years old."

Though cocaine was rediscovered during the hippie rebellion of the 60s, it has been only in the past couple of years that a really heavy trade in the drug has developed. Federal agents seized only 16.4 pounds in 1964. That grew to 96.8 in 1968, 407 in 1971 and 1,232 in 1975. But they have been intercepting only a minute fraction of the illegal drugs coming into the United States.

Comparing Cancer to Pneumonia. True to form for today's decadent culture, what started out as a drug-

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induced thrill has become, in some circles, a crusade for personal freedom.

The inevitable call has gone out to decriminalize cocaine. Proponents argue that "it's safer than alcohol and heroin; "cocaine is as harmless as coffee"; "we allow and promote the use of other psychoactive agents (such as caffeine, tobacco, alcohol, tranquilizers, etc.), so why not coke?" And so forth.

Many of the slogans and arguments made on cocaine's behalf are misleading and irresponsible. To compare the relative merits or demerits of various psychoactive drugs is to obscure the central fact that *no drug is perfectly safe*. All drugs have undesirable side effects.

It's true that cocaine doesn't have some of the dramatic side effects such drugs as, say, heroin or amphetamines. But cocaine presents hazards to mind and body in its own right. To compare it with heroin is, in the words of one drug enforcement official, "like comparing cancer to pneumonia."

To further exacerbate the debate, opponents of cocaine are often blinded by certain misconceptions—or just plain ignorance—and issue misleading and irresponsible statements of their own. They seem to forget that each culture sanctions the use of certain psychoactive drugs. Those who decry the corrosion of the national fiber through psychoactive drugs often use several—usually alcohol, tobacco and coffee—themselves!

The current rage for cocaine must be placed in the context of the drug revolution of the past decade. And that revolution in turn must be placed in the context of the recreational use of psychoactive drugs by almost every culture down through history.

The issues are complex and there are no easy answers for countries that are wrestling with the problem of which mind-altering drugs should be sanctioned and which should be taboo.

For an overall look at today's drug problem, write to one of the addresses on the back cover for your free copy of our booklet *The Dilemma of Drugs*. □

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ANGEL DUST— Another Bad Trip

A boy in Detroit, Michigan, is picked up by police, screaming that one of the policemen has turned into a giant bat. A man in Washington D.C., is arrested while singing naked in a supermarket. A San Francisco Bay Area man kills his mother, father and grandfather. The common denominator in these bizarre behaviors is that each person was under the influence of angel dust or PCP—the latest fad drug to capture the fancy and consciousness of young people. Called by various names on the street—hog, superweed, lovely, goon, and superkools—the technical name for angel dust is phencyclidine hydrochloride (PCP for short.) It was first developed as a tranquilizer in the 1950s, but the drug was abandoned because it led to unpredictable and violent side effects. During the youth revolution of the 60s it made a brief appearance on the drug scene. It is believed to have first been used for fun and freaking out at the 1967 Monterey Pop Festival. But its undesirable side effects were too frightening; it quickly faded from popular use within a year.

More Prevalent Than Pot. About three years ago it started to make a comeback, leading to a gradual rise in the number of PCP-induced "bad trips" treated in emergency wards of hospitals. By the beginning of 1977 its use was widespread enough to constitute a major drug problem. During January and February of that year, an average of 80 PCP-related emergencies were reported each month in Los Angeles County. That compares with 51 monthly in 1976 and 10 a month in 1975. In New York City, reported incidents of emergency treatment for PCP usage rose from 13 percent of all drug emergencies in 1973 to 32 in July-August of 1975, and to nearly 43 percent in the last three months of 1976. Similar sharp rises in its use were soon being reported elsewhere. Today, drug officials say that PCP is becoming in white neighborhoods what heroin has been in the black ghettos. "It's clearly the drug of choice among white suburban teenagers," says Theodore Vernier, director of the Federal Drug Enforcement Agency in Detroit. "Our undercover information is that PCP is more prevalent than marijuana in some high schools," reports Los Angeles drug officer Michael Guy. In the San Francisco Bay Area, authorities attribute over a dozen deaths last year to overdoses of PCP. Nearly a third of San Diego's 126 overdose deaths in the past year are linked to the drug. In Montgomery County, Maryland, police connect several killings and suicides to PCP use. (Authorities believe many PCP-related deaths are overlooked in coroner's reports because they appear to be accidents—drownings, deaths by fire, falls, etc.—involving people whose judgment and coordination have been adversely affected by the drug. Thus, for example, although only one death in Los Angeles County, California, was officially attributed to PCP, Dr. Leon Marder, director of the Drug Treatment Center at Rancho Los Amigos Hospital, estimates that the true figure was more like 30).

Cheap, Simple to Make. Why the popularity of PCP? For one thing, it's cheap, especially when compared with other illicit drugs such as cocaine and heroin, whose prices have risen sharply in the past year. Typically, a dose of PCP can be bought on the street for $1, a half gram for about $10 to $12. Another factor in its favor is the ease which it can be produced. PCP can be made locally and quickly with simple equipment and readily available ingredients. Lt. D.D. Williams of the Houston, Texas drug squad says, "Unlike heroin, which comes from out of the country, it is a domestic phenomenon. It's obviously simple enough that a first-or second-year chemistry student can make it." Fly-by-night chemical plants-known as "pig outfits"—have sprung up across the country. Their profits are enormous, according to John Van Diver, Western regional director of the Federal Drug Enforcement Administration. He says that some laboratories that formerly produced illicit LSD and amphetamines have switched to PCP because the ingredients are easier to process with a smaller investment. Then there is the factor of novelty—young people looking for a new drug experience, a different high. PCP has that, all right, but the price that may be paid in terms of baneful effects on the human mind may not be worth the "trip."

Unpredictable Side Effects. Usually produced as a white powder, PCP can be sniffed, like cocaine, smoked as an additive to marijuana, oregano or parsley, chewed on mint leaves or injected. Those who have taken PCP describe its more benign effects as like that of very strong marijuana. One user said it is like "a combination of taking LSD and sniffing glue." At best, it provides a mellow sensual or dreamy experience. Users feel the effects within two to five minutes after smoking a small amount, and the feeling peaks in about 15 to 30 minutes. The high continues for four to six hours, but the user does not feel normal for 24 to 48 hours. Unfortunately, there is no way that one can guarantee a good trip with PCP. "The tragedy is that most people experience angel dust as some unusual form of marijuana and associate it with the benign patterns of marijuana, but it's anything but that—it's a real terror of a drug," says Dr. Robert L. Dupont, director of the National Institute on Drug Abuse. In truth, PCP can have bizarre and totally unpredictable effects on the mind of the user. "The extreme unpredictability

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of behavior is one of the most frightening things about angel dust," says Steve Lerner, a psychologist at R. Stanley Burns and Associates, a San Francisco-based group that has been studying the drug for almost four years. In controlled experiments using moderate doses, PCP has produced periods of stupor or even coma lasting for hours or days. In acute cases, according to the Drug Enforcement Administration, the drug has caused some users to be in a confused state of mind for up to two weeks, followed by a psychosis that lasts for several weeks. The psychosis closely resembles paranoid schizophrenia. These results were obtained from PCP manufactured legally under rigid controls and purity standards and administered under supervision. How it affects the user in the uncontrolled, unsupervised conditions of the street was summarized in a recent article in the *Journal of the American Medical Association*: "unpredictable destructiveness," with users, "running aimlessly, performing bizarre actions, striking bystanders," or attempting to commit suicide.

"People can use terrible, terrible judgment when they have been using PCP," says Dr. Gerald Crary of the Los Angeles County-USC Medical Center. "They think they can stop a train with their finger, or they can fly. Many of them are really terrified, frightened, confused," he states. "Some people will flip out on a low or normal dose."

Physicians say that there is no direct antidote for PCP, and its toxicity, unlike that of other psychoactive drugs, can last for weeks.

Because of its unpredictable effects, many hard-core drug users scorn it as a "freak drug," and some street dealers misrepresent the drug to be cocaine, LSD, heroin or THC, the active ingredient in marijuana, in selling it to unsuspecting users.

Recently, PCP has also been used to "boost" cocaine and heroin that has been diluted or "cut" to two to three percent purity to produce higher profits.

A youth emerging from a five-day PCP coma in San Diego said he thought he had been buying bargain-priced cocaine. He remained in a psychotic state for a month and is still confined to a mental hospital with frontal-lobe brain damage.

Although many youngsters may be unsuspecting users of the drug, which can be detected only by chemical analysis, others have acquired a bravado craze for it.

"Even though they're gambling with death, many high school kids consider PCP to be very macho," says Howard D. Young of the San Diego Department of Substance Abuse. "If you can handle it, then you're supposed to be a man."

PCP is another in a long list of psychoactive drugs used for fun and pleasure by a large number of young people and adults since the drug revolution of the 1960s. A lot of drug use is—and always has been—experimental. It's something people do maybe once or twice out of curiosity or peer pressure.

Drug Abuse Syndrome. But a significant minority of young people and adults continue to use drugs over and over. Once upon a time, drug cultists were tripping on LSD, then floating high on cocaine, then spaced out on marijuana. Now they are freaking out on angel dust. The drug fads come and go, but the underlying problems remain the same. Drug abuse is a symptom of a society that is failing to meet individual human needs. Drugs stand in for whatever is missing in life. They are a buffer from problems people don't know how to cope with in real life. They provide stimulation when there is nothing else stimulating to do. They are a dramatic way of killing time—and maybe killing oneself. □

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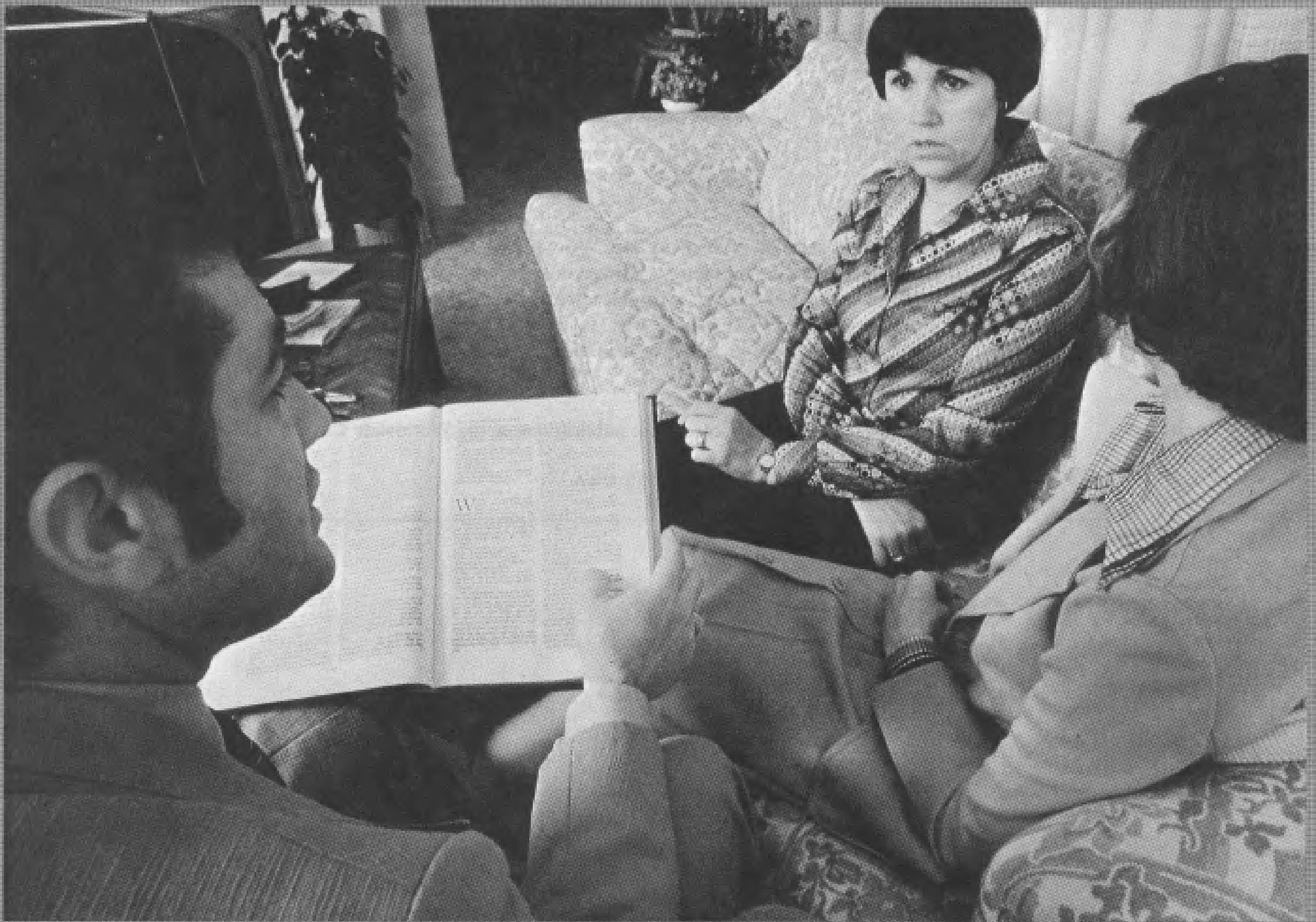

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