ON THE HORIZON

Acupuncture: New Perspectives in Chemical Dependency Treatment

SANTA BARBARA, CALIFORNIA

Abstract — The use of auricular acupuncture in treating acute drug withdrawal began in Hong Kong in 1972. Its practical application in the traditional drug treatment setting evolved at New York City's Lincoln Hospital during the 1970s, and over 250 acupuncture programs in diverse treatment settings have since been established worldwide, based on the Lincoln protocol. Acupuncture treatment offers the client support during acute and postacute withdrawal through relief of classic symptoms. It has also been found useful as an entry point to treatment and/or recovery in such nontreatment settings as jails and shelters, and has particular efficacy in the treatment of resistant clients, and of prepartum and postpartum women. Though acceptance of the legitimacy of acupuncture by the chemical dependency community has been guarded, both research and outcome studies indicate that it holds promise as a complement to traditional substance abuse modalities.

Keywords — acupuncture; addiction; alcoholism; Chinese medicine; cocaine; criminal justice; detoxification; heroin; intravenous drug users; maternal substance abuse; relapse prevention; resistant clients; substance abuse; treatment; urine testing; withdrawal.

Acupuncture has, according to Porkert and Ullman (1988, p. 37), "stubbornly and successfully resisted assimilation" into Western medical science. This is perhaps less the case in Europe. In fact, auricular (ear) acupuncture, which is used in the chemical dependency treatment setting, is in part a European as well as a Chinese development. Acupuncture as it came to be used in Europe is itself a hybrid of Chinese acupuncture, which is only a small part of traditional Chinese medicine, whose primary emphasis is on herbs. Acupuncture protocols were passed along in Europe beginning in the early 17th century in pamphlets that were filled with contradictory information concerning point location and diagnoses. Curiously, during the
Despite the fairly extensive research in this area, precisely how acupuncture works remains a mystery, at least to the Western scientific mind. Most simply, it can be said that acupuncture moves energy. In the Chinese view of the body, life energy, or chi, circulates through pathways that are called, in the West, "meridians." "Disease" is seen as a stagnation, blockage, or deficiency of this energy. The acupuncturist places needles which, based upon diagnosis, will stimulate an opening of and, therefore, a movement of energy through the appropriate pathways. The effect is homeostatic. For example, a person with an excess of stomach acid who is needled at a point called "Stomach 36" will experience a decrease in the amount of acid in the stomach: a person with a stomach acid deficiency, needled at the same point, will experience an increase in stomach acid (Sodipo & Falaiye, 1979). Again, the mechanism of action involved in this phenomenon is not known.

Acupuncture is not a panacea, and it loses much of its efficacy in the treatment of chemical dependency when practiced in isolation from the more traditional Western modalities of counseling, pharmaceutical therapies, 12-step programs, and urine testing. It is best seen as an adjunct or a complement to these other forms, and, in this regard, it is an exceedingly fluid modality. We are beginning to see that, properly used, it can enhance and support the program goals of virtually any traditional chemical dependency treatment setting.

When used in an inpatient detoxification setting, alcoholic seizures virtually disappear, even without the use of pharmaceutical intervention. One of the first residential detox programs to implement acupuncture was Portland, Oregon's, Hooper Memorial Detox Center in 1987. Clients entering this 5-day residential detox-to-referral program were 6 times less likely to return in the following 6 months than clients who entered the facility prior to the implementation of twice-daily acupuncture, and the program's overall completion rate increased from 60% to 92% (Lane, 1988). A residential, social model, detox-to-referral program operated by Santa Barbara, California's, Counsel on Alcoholism and Drug Abuse opened in June of 1991, offering twice-daily acupuncture. Only 2 alcoholic seizures were reported out of the first 150 clients, the majority of whom were late stage, chronic alcoholics, and completion rates for the program are comparable to Hooper's (Brumbaugh, 1992). In the treatment of acute heroin withdrawal, acupuncture is also effective, the symptoms of “kicking” often resembling a mild flu. And the cravings, anxiety, and depression of crack cocaine withdrawal become manageable.

Subjectively, acupuncture treatment offers to the client support during acute withdrawal through relief of classic withdrawal symptoms. According to Michael
Smith, M.D. (1979), the body's response to acute withdrawal from toxic drugs is a “crisis in elimination,” which is seen as a “healing crisis.” He suggests (Smith & Kahn, 1988) that “acupuncture works by releasing blockages of energy and correcting imbalances of energy flow,” and that its physiologic effects also likely involve homeostatic action on the autonomic nervous system, various neurotransmitters, and elements in the pituitary subcortical axis.

In an outpatient, residential, or day treatment setting, counseling sessions are greatly enhanced by the relaxed and nonhostile ambience created by the acupuncture treatments, and it provides a useful tool in dealing with the otherwise virtually nontreatable symptoms of “protracted abstinence syndrome” or “post-acute” withdrawal. Used in conjunction with daily urine testing in the outpatient setting, it provides a higher ground for the counselor in dealing with the perplexing issues of relapse and relapse prevention.

Acupuncture is also well suited as an entry point to treatment and/or recovery in such diverse nontreatment settings as jails, public defender's offices, homeless and battered women's shelters, and neighborhood community centers and medical clinics. In this latter arena, it is providing not only an entry point into treatment/recovery for the chemically dependent client, but also a long awaited entry point into general medicine for acupuncture itself. For example, a program of the Multicultural Inquiry and Research on AIDS (MIRA) Clinic located in Bayview-Hunter's Point, San Francisco, under the auspices of the University of California San Francisco Center for AIDS Prevention and San Francisco General Hospital, was started to study the effects of acupuncture on the detoxification of heroin addicts, and has subsequently expanded to include general medicine. Acupuncture is also now in use in general medical treatment at Lincoln Hospital in The Bronx, New York, where it began as a treatment for acute drug withdrawal.

It is important to note in this regard that acupuncture offers the unique feature of more expansive protocols to address physical and psychological conditions that may have been precipitative factors in the chemical dependency, such as chronic pain or depression, conditions which may have discouraged clients in chemical dependency recovery. With acupuncture, integrated and drug-free treatment options are immediately available for such "relapse trigger" pathologies that may become unmasked as chemical abstinence is achieved. This can be especially helpful in the treatment of dual diagnosis clients, since Chinese Medicine has been shown to be effective in the treatment of depression, chronic anxiety, mania, insomnia, schizophrenia, and other mental disorders (Bensoussan, 1990, pp. 39-41, 109).

The use of auricular acupuncture in treating acute drug withdrawal began in Hong Kong in 1972. It was used sporadically throughout the United States during the 1970s, and some experimentation with the method was done at the Haight Ashbury Free Clinic in San Francisco (Seymour & Smith, 1987). But it has been at Lincoln Hospital in New York, under the guidance of Michael O. Smith, M.D., Director of the Hospital's Division of Substance Abuse, that the protocol has been refined and expanded, and has taken its firmer root.

Lincoln is located in the South Bronx where alcoholism and drug addiction have been endemic for many years. Smith's clinic was primarily a methadone program in 1973 when he first read of Dr. H.L. Wen's research in Hong Kong (Wen & Cheung, 1973) concerning the treatment of heroin withdrawal with acupuncture. Dr. Wen, a neurosurgeon, had made his initial discovery while administering acupuncture anesthesia to a patient who happened to be in heroin withdrawal. The withdrawal symptoms disappeared, and Wen subsequently conducted a formalized study. By 1980, Wen had replicated the positive outcomes of his research and published no fewer than 10 additional studies (Bensoussan, 1990, pp. 101-126) concerning narcotic withdrawal symptoms and acupuncture, including research on the adjunctive use of the opiate block naloxone to essentially flush opiates from receptor sites in the brain to speed up the detoxification process. It was discovered that naloxone also partially blocked the effects of acupuncture itself. This led to additional research on the relationship of acupuncture to the production of endogenous opiates.

Smith, interested in potential alternatives to methadone treatment, began employing Chinese doctors at Lincoln to experiment with different protocols in the treatment of heroin addiction. Wen's research had involved electrical stimulation as well, and Lincoln Hospital experimented extensively with electrostimulation protocols, eventually discontinuing its use when it was discovered that manual acupuncture resulted in more consistent clinical outcomes. A 5-point auricular protocol was eventually established, consisting of 4 to 5 points in each ear, including kidney, liver, lung (or heart), sympathetic, and shenmen. By 1975, acupuncture had become a permanent feature of the Lincoln program, not only for heroin dependence, but for alcoholic patients as well. And, in 1985, when the “crack” cocaine epidemic reached New York, it was discovered that the same protocol was effective in addressing the cravings, anxiety, and dysphoria accompanying “crack” withdrawal (Lipton, Brewington, & Smith, 1990; Smith, 1988).

In 1985, Smith founded the National Acupuncture Detoxification Association (NADA, 3115 Broadway, #51, New York NY 10027), an organization representative of experts in chemical dependency as well as
Oriental Medicine. NADA’s function is to provide training and consultation to treatment programs that have begun throughout the world and to assure specific clinical and ethical standards in the certification of “acupuncture detox specialists.”

Though much of NADA’s focus as well as the research has been upon the acute detoxification phase of withdrawal, clinical experience since NADA was established has shown that acupuncture has applications as well for postacute or “latent” withdrawal. Clients return to the acupuncture clinic months and even years into recovery for “tune-ups.” Many clients find the far more expansive application of traditional Chinese medicine to be a valuable tool in treating the anxiety-depression-craving phenomenon that Edward Brecher (1972) termed the “post-addiction syndrome.” These symptoms, as well as the majority of Terence Gorski’s symptoms that forebode alcoholic relapse (1987) correspond with “disorders of the spirit” in the classic Chinese medical texts and are very responsive to traditional Chinese medical treatment, which includes herbs as well as acupuncture (Kaptchuk, 1983, pp. 45–46).

Oriental medical schools, however, in which acupuncturists receive their education and training, are generally as deficient in chemical dependency curricula as are their Western counterparts. Therefore, a primary role of NADA is to provide acupuncturists with basic education in chemical dependency and recovery through intensive 3-day NADA certification training coupled with a clinical internship. Chemical dependency professionals working in the acupuncture program also benefit from this training, since clinical success requires a complementary relationship between the counseling and acupuncture aspects of the treatment program. In regions of the country where the number of licensed acupuncturists has been insufficient to meet the demand for service levels, state laws governing the practice of acupuncture have been modified to allow for “acupuncture detoxification specialists”—generally chemical dependency counselors or nurses who are specially trained to perform auricular treatment only when working under the supervision of a licensed or certified acupuncturist. This has created a new level of professional supervisory positions for acupuncturists as well as a potential entry point into the acupuncture profession for people working in the recovery field.

The NADA protocol has a precise focus, elegant in its simplicity. In its original application in the outpatient, drop-in setting, the clinic is to be, like the 12-step program, “barrier-free” in that there are no motivational or other screening requirements for entering or continuing acupuncture treatment. Clients are instructed to come as “clean and sober as they can” for treatment, and treatment is recommended daily, in the same “one day at a time” rhythm as recovery, so that the treatment, as Michael Smith has said, “will be as reliable as the drug was.” While 12-step meetings are frequently held in proximity to the clinic, and while group and individual counseling is generally available on site, participation in these activities is not a condition of receiving acupuncture treatment.

The clinic protocol is to be “empowering,” in that clients do everything they can for themselves, such as “prepping” their own ears with an alcohol solution and cotton. In some NADA clinics, clients select their own personal autoclaved or pre-packaged disposable needles. Often, clients even use a mirror to remove their own needles upon leaving. The acupuncture staff are counseled not to “fuss” with clients, question them as to relapse, or lecture or confront them in any way. Clinic rules are minimal, and clients are barred from treatment only for disruptive behavior. Such instances are rare in this setting.

The NADA protocol includes “sleep mix” tea, a recipe also developed at Lincoln (Smith, 1979), using the Western herbs chamomile, hops, catnip (sometimes substituted with valerian root), scullcap, peppermint, and yarrow. Clients drink it during or following treatment and are encouraged to take it home to help them sleep.

Clients are treated for 45 minutes in a group setting, seated. Talking—especially drug-talk and “war stories”—is discouraged. In observing this process, where there are no behavioral or cognitive expectations placed on the clients, where clients are “free to do nothing,” one gets a sense of some of the more discreet resonances between this modality and the form and structure of the 12-step meeting. There is an implicit trust established in the client’s ability to find his own way in recovery, and the responsibility of the clinic is to make available the most helpful tools for the task.

This clinical ambience is often unsettling at first for new clients, especially the more “treatment-seasoned” ones. They may spend the first few days of treatment waiting for “the program” to begin. They will perhaps “test” the program by “chipping” or coming under the influence, and find that they are welcomed back just the same. While traditional alcohol and other drug treatment strategies require an external focus, here, in the NADA clinic, the attention of the client is invited inward, where the ultimate responsibility for recovery lies.

According to John D. McPeake, B.P. Kennedy, and S.M. Gordon (1991), a shortcoming of traditional alcohol and drug treatment is that it ignores a primary motivation for drug use, which is mood modification. One aspect of the efficacy of acupuncture may be that, to degrees that vary with individual clients, the treatment elicits an experience of altered consciousness. Heroin addicts often self-report euphoria as an altered mood response to acupuncture, induction of which has
shown a tendency to reduce baseline withdrawal and craving (Childress, McLellan, Natale, & O'Brien, 1986).

An additional subjective effect of the treatment is a feeling of relaxation and stress-reduction. For this reason, it is not unusual in acupuncture clinics to see counselors or other staff receiving treatment with the clients.

NADA held its first annual convention in February, 1991, in Santa Barbara, California. The roster was dominated not by chemical dependency professionals nor by acupuncturists but by representatives of the criminal justice community, including Superior Court Judge Herbert Kelin, former "Drug Czar" of Dade County, Florida; Mark Cunniff, Executive Director of the National Association of Criminal Justice Planners in Washington, D.C.; and Orville Pung, Commissioner of Corrections, and James Bruton, Director of Adult Release, of the Minnesota State Department of Corrections. Local presenters included the Santa Barbara Chief of Police, and the Director of Administrative Services for the Santa Barbara County Department of Probation. They came, as advertised in the conference brochure, to herald the arrival of a "new beacon on the horizon, 1991, in Santa Barbara, California. The roster was dominated not by chemical dependency professionals nor by acupuncturists but by representatives of the criminal justice community, including Superior Court Judge Herbert Kelin, former "Drug Czar" of Dade County, Florida; Mark Cunniff, Executive Director of the National Association of Criminal Justice Planners in Washington, D.C.; and Orville Pung, Commissioner of Corrections, and James Bruton, Director of Adult Release, of the Minnesota State Department of Corrections. Local presenters included the Santa Barbara Chief of Police, and the Director of Administrative Services for the Santa Barbara County Department of Probation. They came, as advertised in the conference brochure, to herald the arrival of a "new beacon on the dark landscape of chemical dependency treatment."

That the strongest advocates for acupuncture treatment for chemical dependency are members of the criminal justice community is echoed by the fact that much of the funding for acupuncture-based chemical dependency programs in the United States comes not through traditional drug and alcohol sources but through criminal justice sources. There are clinical reasons for this, and they reveal a great deal about the efficacy of acupuncture, and have resulted in a growing bias among practitioners in this field that the premier "window of opportunity" for intervention in drug treatment lies on the continuum of arrest, judication, incarceration, and probation or parole of the drug offender.

The standard scepticism about drug and alcohol treatment in general in the law and justice community derives from the fact that law enforcement and treatment have traditionally labored under conflicting definitions of alcoholism and drug addiction. The clinical (and recovering) community has long accepted the disease of alcoholism/addiction as a chronic relapsing disorder in which recovery is typically achieved only through a process of "slips and starts." For this reason, there has been a shift in chemical dependency treatment away from the concept of detoxification and toward relapse prevention or "sobriety maintenance." Clinical experience is clear that rare is the addict or alcoholic who negotiates the transition from use to nonuse in a single movement.

While individual judges, probation, or parole officers may indeed be personally aware of this relapsing nature of typical early recovery, the criminal justice system itself has not been able to tolerate relapse since its charge is not to bring about recovery per se, but to prevent the resumption of the criminal behavior that relapse precipitates. This "hard line" either/or definition of recovery as requiring total and continuing abstinence has been justified, for in traditional drug and alcohol treatment, relapse is generally catastrophic, resulting in treatment drop-out. This is true of course in residential intensive or social model treatment, often the "treatment of choice" for the most chronic addicts and alcoholics, because a "clean and sober" living environment is tantamount to the program's success. But it is also true of outpatient treatment modalities because of the special difficulties of the chemical dependency counselor in dealing with the problems of relapse.

In the highly successful acupuncture-based drug diversion programs, however, in such varied locations as New York City; Miami; Portland, Oregon; and Santa Barbara and Santa Maria, California; a higher ground can be taken by the judge or probation or parole officer, because the acupuncture-based program is able to keep the client in treatment during the early relapsing period. Relapses here tend to be shallow and noncatastrophic. Clients "keep coming back," and, over time, abstinence is achieved. Dade County Judge Stanley Goldstein, who presides in Miami over a "drug court" that hears only first and second cocaine offenses, began diverting offenders to a 3-phase treatment program in October 1989. The first phase of the program involves daily acupuncture and urine testing. Defendants return to court during this phase, and Judge Goldstein reviews their urinalysis records. His response to intermittent positive tests is not punitive; rather, he encourages defendants in their struggle and commends them for the "clean" days they have achieved. This unusual posture of relapse tolerance is well justified, for of the first 1,200 defendants to complete the first phase of the program, only 7 were rearrested during the first 6 months (Konefal, 1990), compared with an average 2-week re-arrest time for this population prior to implementation of the program.

The concept of daily urine testing as it is used in Miami was also a development of the Lincoln Hospital program. The notion of urine testing in a therapeutic setting may seem at first an anathema, since urine testing is traditionally punitive, a clear manifestation of judgmentalism, giving the treatment program the role of critic rather than supporter of the client's recovery process. In practice, however, quite the opposite turns out to be the case. The goal is not punitive disclosure but education and therapeutic feedback. Unlike urine testing in a law enforcement setting, clients assume much of the responsibility for self-monitoring the urinalysis process. Fears that clients will provide fraudulent test results under these conditions have not been justified. As Michael Smith has aptly said, "drug addicts lie, but they don't lie every day." Once the daily
treatment rhythm has been established, and once the client has learned that a positive urine test will not result in program expulsion, attempts to deliver "false negatives" are uncommon.

To fully understand the utility of such testing, a brief examination of the dynamics of relapse may be helpful. In the traditional relationship between a chemical dependency counselor and client, there is an implicit trap surrounding the issue of relapse. In the Rogerian and other generally accepted models of chemical dependency counseling, the appropriate posture of the counselor is one of nonjudgmental acceptance. The overt agenda is to validate the experience and feelings of the client. Trust is, of course, a necessary prerequisite for this stance. Honesty, particularly self-honesty, is the hallmark of recovery. The counselor wants the client to be honest about his or her feelings and behavior. And, if the counselor is skilled, the trust and honesty will come early in the relationship, because the client desires it as well. It will become part of what is called in recovery the "honeymoon" period—generally the first 30 days.

The difficulty, of course, is that both counselor and client know that addiction is a disease characterized by relapse. The counselor cannot, in good conscience, validate relapse when it happens because the overriding covert agenda in the relationship is for the client to stop relapsing. This agenda implies, of course, judgement, which is contrary to the goal of therapy.

This is a bind, and one to which the client is not insensitive. If the counselor has done a particularly good job and has won the trust of the client, then, when the generally inevitable relapse occurs, the client’s usual move will be to drop out of treatment so as to “protect the counselor from disappointment.”

Daily urine testing in a therapeutic acupuncture-based setting discharges this dilemma. At Lincoln, and in other similar programs, the computer software interfaces with an on-site urine testing machine. With substantial client numbers, the cost of urinalysis for the single drug for which the client has been referred to treatment can be reduced to as little as a dollar and a half per test. Multiple client urines are tested at once, and the data is downloaded to the client’s attendance file. A print-out of urine toxicity patterns over the period of the client’s treatment attendance can be generated while the client is having acupuncture. A subsequent counseling session that begins with the client having this print-out in hand can commence at an entirely different therapeutic level, free from the potentially codependent "how are you doing?", because "how the client is doing" is already objectively established. The content of the answer to the question, "how are you doing?" is not being elicited by the counselor. Nor does the answer depend upon the client’s best recollection of when he or she last used, but rather has been provided by the client’s own body, so one important element of denial is also dispelled. Clinical experience shows that clients come to enjoy this daily feedback. It can perhaps be likened to a person who is trying to lose weight stepping on the scale each morning.

A significant barrier to treatment in criminal justice settings is that acupuncture is designated by Federal law as an "experimental procedure," thus precluding mandated application among incarcerated, probated and paroled populations. Its current use is therefore limited to those who “volunteer” for treatment. Ever so, the use of the auricular acupuncture protocol in incarcerated settings illustrates its application beyond the detoxification phase and its potential for addressing some of the social and economic problems attending chemical dependency.

In Minnesota, it has been integrated into 4 state prison treatment programs, one of which is a research program. Elsewhere, the protocol has been to treat inmates with a history of chemical dependency daily for 30 days prior to their release. In the Dade County Stockade in Miami, from late 1989 to the present, the number of inmates treated in this manner has grown from 140 to 527. An independent research project to study the impact of this treatment on re-arrest has just begun as of this writing. Similar programs have begun in Santa Clara, San Luis Obispo, and Santa Barbara Counties in California. A preliminary study of Santa Barbara County Jail inmates indicates that those receiving 24 or more treatments during the last 30 days of their incarceration are two-thirds less likely to be re-arrested in the 2 months following release than those receiving 6 or fewer treatments (Brumbaugh & Wheeler, 1991). In that an acupuncturist can treat as many as 35 inmates in an hour, this treatment modality shows great promise as a cost-effective method of inmate reduction in our vastly overcrowded jails.

Also promising is the use of acupuncture in homeless shelters, where alcohol and drug treatment is often resisted due to the unmanageability of withdrawal symptoms in such a setting, and where shelter client safety has become an increasing concern. A Santa Barbara program operates an acute detoxification program with clients who are under the custodial care of a homeless shelter at night. Clients receive two acupuncture treatments daily, and the program has had a minimum of withdrawal-related medical emergencies, seizures, or social altercations. Shelter staff report that the program has had a positive effect on management of the facility in general. The program has a 90% program completion and aftercare program placement rate (Brumbaugh, 1992).

Acupuncture treatment has also found successful application in the treatment of chemically dependent prepartum and postpartum women (Ackerman, 1991), and a variation of the protocol is being used to treat chemically exposed infants (Keenan, 1991). Clinics that use acupuncture as part of the treatment design and that are specifically focused on the needs of pregnant
women are now in operation at Lincoln Hospital (Smith, 1990), at the MIRA Clinic at Bayview-Hunter's Point in San Francisco, in Miami at the Metro/Dade Office of Rehabilitation Services, and in St. Paul, Minnesota, at the Maternal Child Project.

Acupuncture is of particular efficacy with prenatal women, because, while it is well known that the common substances of abuse such as alcohol, cocaine, heroin, amphetamines, PCE, and marijuana have documented teratogenic potential for the fetus (NAPARE, 1989), medications used to accomplish detoxification are also teratogenic (Cregler & Mark, 1986). There is concern that abrupt withdrawal during pregnancy may be damaging to the mother and fetus. Acupuncture reduces this risk by supporting the process of withdrawal and avoiding the impact of sudden abstinence.

The enthusiastic law enforcement speakers at the 1991 NADA conference were, unfortunately, "preaching to the converted," for the small audience was comprised largely of people already working in this frontier field. Although there are now over 175 acupuncture-based chemical dependency programs operating in the United States, and dozens more elsewhere in the world, acceptance of acupuncture as a legitimate treatment component by the chemical dependency community has been, at best, guarded. In the areas of the country where acupuncture has flourished, it is highly localized. While it has a firm foothold, for example, in the chemical dependency treatment delivery systems in the cities and regions mentioned above, it has failed to gain acceptance with the departments of drugs and alcohol in any of the states where these programs exist. The single exception as of this writing is New York, where the State's Division of Substance Abuse Services recently released a concept paper (Puccio, 1991) strongly advocating acupuncture as a "threshold technology," most effective in "assisting cocaine and/or alcohol addicted clients who resist initial treatment." Acupuncture, according to the paper, "works in concert with traditional drug abuse treatment approaches (and) transcends the barriers to all treatment components."

Acceptance at the Federal level is also reserved. A February 1991 memo from the National Institute on Drug Abuse (NIDA) to the U.S. Congress Select Committee on Narcotics Abuse, states that they feel this treatment modality "shows some promise," but that more research is required (Egertson, 1991). The only acupuncture research they are currently funding is a new cocaine treatment research project in Minneapolis and a 3-year study in Miami focused on IV needle use. At less than $1,000,000 each, these are among the smallest of NIDA's current research grants. Miami is a 3-phase grant. The first phase has been completed, and the experimental group receiving acupuncture has demonstrated a faster rate of delivering clean urines than groups receiving counseling only. Also of interest is that, with acupuncture, court referred clients responded more favorably than self-referred clients (Grossman, National Institute on Drug Abuse, personal interview, July 1992).

The Federal Office of Treatment Improvement (OTI), in their first funding cycle in 1990, received one application that included acupuncture. They denied the application by a 5-to-4 vote, questioning "the efficacy of the use of acupuncture in (the treatment of high-risk narcotics addict probationers)" (OTI, 1990). Due in part to the lobbying efforts of the National Association of Criminal Justice Planners, OTI's director Beny Primm has since been quoted as stating that future funding applications to OTI will not be denied "solely on the basis that they contain acupuncture components" (Cunniff, Executive Director, The National Association of Criminal Justice Planners, 1331 H Street N.W., Suite 401, Washington, DC 20005; 1991). Charles Rangel (1990), Chairman of the Select Committee on Narcotics Abuse and Control, in a letter to Beny Primm in July of 1990, perhaps also contributed to the softening of OTI's position by stating that "acupuncture (though) not, as yet, fully understood . . . should not be overlooked or rejected off-hand." Citing the dramatic success of the cocaine diversion program in Miami, Rangel went on to say that "This is precisely the kind of innovative experiment that Congress has provided for through demonstration grant funds. I strongly urge you to look into this program, to consider it objectively, with an open mind and without pre-judgment."

But again, such support is isolated. In the voluminous triennial report of the Department of Health and Human Resources (DHHS, 1991) to Congress, in their cataloging of innovative new drug treatment modalities, mention is made of such experimental treatment tools as pocket computers by which nicotine addicts can keep track of the number of cigarettes smoked during the day, but there is no mention of acupuncture in the document.

This resistance, often tacit, like the Western cultural resistance to acupuncture in general, is understandable. Acupuncture, and the "invisible circulatory energy" paradigm of the organism upon which it is based, is implicitly nonrational. In that its basic premises about the body are based upon energetic rather than somatic considerations (Porkert & Ullman, 1988, pp. 13-63, 265-278), it is in fundamental conflict with Western medical and scientific philosophy, from which current drug treatment strategies and theories have developed. Like Alcoholics Anonymous, itself a historical and cultural reaction against Western "scientism" (Kurtz, 1979, p. 171), acupuncture addresses addictive disorder on a "nonrationalistic" and subjective plane where the issues of recovery lie not in the relationship of the addict with the external world or "fix," but rather in relationship with self, in the possibility of healing from within. Oriental medicine characterizes addiction in terms such as "yin deficiency," "stuck liver chi," and
“empty fire syndrome.” Such unfamiliar and “non-medical” tautology is not easily embraced by the “rational” Western drug treatment establishment.

However, in addition to the studies already cited, some research under the parameters of Western scientific investigation has been achieved. In 1987 in a medically supervised study of chronic homeless alcoholic men in Hennepin County, Minnesota, 80 subjects were divided into 2 groups matched for drinking history and prior treatment experience. The control group were given sham acupuncture, needled at nontherapeutic points a few millimeters away from standard treatment points; 53% of the treatment group completed the 8-week treatment regimen, compared with 2.5% of the control group. During the 6-month follow-up of the 2 groups, the control group had more than twice as many drinking episodes and had to be re-admitted to detox more than twice as often as the experimental group (Bullock, Culliton, & Olander, 1989). These same researchers are currently comparing acupuncture with Valium in treating the symptoms of acute alcohol withdrawal, and are the recipients of the new NIDA cocaine treatment research grant.

A similar placebo-type study was done at Bayview-Hunter’s Point Clinic comparing methadone and acupuncture in the detoxification from heroin. This 3-phase, 1-year study was commissioned by the California legislature. A report to the legislature indicates that acupuncture clients were more likely to have clean urinalysis and reported longer periods of abstinence with fewer problem days than their methadone controls (TRIAD, 1991).

One of the non-criminal-justice speakers at the 1991 NADA Conference was Robert Olander, Commissioner of Chemical Health for Hennepin County, Minnesota, and one of the active NIDA researchers there. He suggested that there have been three “benchmarks” in the history of alcohol and drug treatment in the United States, three things that have revolutionized the way we do alcohol and drug therapy: first was the founding of Alcoholics Anonymous in 1935; second was the development of pharmaceuticals in the late 1950s and early ‘60s, and the third is acupuncture.

Whether acupuncture indeed deserves a place on this exclusive list remains to be seen. Given the economic and social devastation of the current drug and addiction problem in the United States, however, we are perhaps well advised to reflect upon Rangel’s urging, “to consider it objectively, with an open mind and without prejudgment.”

REFERENCES


Brumbaugh, A. (1902). Acute care program: First year report. (Available from Project Recovery, Santa Barbara Council on Alcoholism and Drug Abuse, P.O. Box 28, Santa Barbara, CA 93102)


Konefal, J. (1990). Acupuncture program services: Mid-year progress report. (Available from University of Miami, School of Medicine, Department of Psychiatry, P.O. Box 016069, Miami FL 33101)


OTI. (1990). Summary statement for Application Number: 1 H87T1
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00112-0103 by the Office of Treatment Improvement, United States Department of Health and Human Services, to Santa Barbara County Drug and Alcohol Program, cover letter dated September 21, 1990.


Rangel, C. (1990, July 11). Chairman, United States House of Representatives Select Committee on Narcotics Abuse and Control, letter to Beny J. Primm, M.D., Associate Administrator, Office of Treatment Improvement, ADAMHA.


Smith, M. (1990). Raising healthy babies for the 90's. (Available through Lincoln Hospital, Maternal Substance Abuse Services, 349 East 140th Street, Bronx NY 10454)


Alex G. Brumbaugh, BA, CAC
Council on Alcoholism and Drug Abuse
Santa Barbara, California