Cannabis As a Substitute for Alcohol

By Tod H. Mikuriya, M.D.

The author has treated 92 patients who report that cannabis use helped them reduce their alcohol consumption in part or entirely.

SUMMARY

Ninety-two Northern Californians using cannabis as an alternative to alcohol obtained letters of approval from the author. Their records were reviewed to determine characteristics of the cohort and efficacy of the treatment —defined as reduced harm to the patient. All patients reported benefit, indicating that for at least a subset of alcoholics, cannabis use is associated with reduced drinking. The cost of alcoholism to individual patients and society-at-large warrants testing of the cannabis-substitution approach and study of the drug-of-choice phenomenon.

KEYWORDS

Addiction, alcohol, alcoholism, cannabis, depression, drug-of-choice, harm reduction, marijuana, pain, substitution.

INTRODUCTION

Physicians who treat alcoholics are familiar with the cycle from drunkenness and disinhibition to withdrawal, drying out, and apology for behavioral lapses, accompanied over time by illness and debility as the patient careens from one crisis to another. (Tamert and Mendelsohn 1969)

"Harm reduction" is a treatment approach that seeks to minimize the occurrence of drug/alcohol addiction and its impacts on the addict/alcoholic and society at large. A harm-reduction approach to alcoholism adopted by 92 of my patients in Northern California involved the substitution of cannabis —with its relatively benign side-effect profile— as their intoxicant of choice.

No clinical trials of the efficacy of cannabis as a subtitute for alcohol are reported in the literature, and there are no papers directly on point prior to my own account (Mikuriya 1970) of a patient who used cannabis consciously and successfully to reduce her problematic drinking.

There are ample references, however, to the use of cannabis as a substitute for opiates (Birch 1889) and as a treatment for delirium tremens (Clendinning 1843, Moreau 1845), which were among the first uses to which it was put by European physicians. Birch described a patient weaned off alcohol by use of opiates, who then became addicted and was weaned off opiates by use of cannabis. "Ability to take food returned. He began to sleep well; his pulse exhibited some volume; and after three weeks he was able to take a turn on the verandah with the aid of a stick. After six weeks he spoke of returning to his post, and I never saw him again."

Birch feared that cannabis itself might be addictive, and recommended against revealing to patients the effective ingredient in their elixir. "Upon one point I would insist —the necessity of concealing the name of the remedial drug from the patient, lest in his endeavor to escape from one form of vice he should fall into another, which can be indulged with facility in any Indian bazaar." This stern warning may have undercut interest in the apparently successful two-stage treatment he was describing.

In the late 19th century in the United States, cannabis was listed as a treatment for delirium tremens in standard medical texts (Edes 1887, Potter 1895) and manuals (Lilly 1898, Merck 1899, Parke Davis 1909). Since delirium tremens signifies advanced alcoholism, we can adduce that patients who were prescribed cannabis and used it on a longterm basis were making a successful substitution.

By 1941, due to prohibition, cannabis was no longer a treatment option, but attempts to identify and synthesize its active ingredients continued (Loewe 1950). A synthetic THC called pyrahexyl was made available to clinical researchers, and one paper from the postwar period reports its successful use in easing the withdrawal symptoms of 59 out of 70 alcoholics. (Thompson and Proctor 1953).

In 1970 the author reported (op cit) on Mrs. A., a 49-year-old female patient whose drinking had become problematic. The patient had observed that when she smoked marijuana socially on weekends, she decreased her alcoholic intake. She was instructed to substitute cannabis any time she felt the urge to drink. This regimen helped her to reduce her alcohol intake to zero. The paper concluded, "It would appear that for selected alcoholics the substitution of smoked cannabis for alcohol may be of marked rehabilitative value. Certainly cannabis is not a panacea, but it warrants further clinical trial in selected cases of alcoholism."

The warranted research could not be carried out under conditions of prohibition, but in private practice and communications with colleagues I encountered more patients like Mrs. A. and generalized that somewhere in the experience of certain alcoholics, cannabis use is discovered to overcome pain and depression —target conditions for which alcohol is originally used— but without the disinhibited emotions or the physiologic damage. By substituting cannabis for alcohol, they can reduce the harm their intoxication causes themselves and others.

Although the increasing use of marijuana starting in the late '60s had renewed interest in its medical properties —including possible use as an alternative to alcohol (Scher 1971)— meaningful research was blocked until the 1990s, when the establishment of "buyers clubs" in California created a potential database of patients who were using cannabis to treat a wide range of conditions. The medical marijuana initiative passed by voters in 1996 mandated that prospective patients get a doctor's approval in order to treat a given condition with cannabis —resulting in an estimated 30,000 physician approvals as of May 2002. (Gieringer 2002)

In a review of my records in the spring of 2002 by Jerry Mandel, PhD, 88 patients were identified as using cannabis to treat alcohol abuse and related problems. This paper describes characteristics of that cohort and the results of their efforts to substitute cannabis for alcohol.

Medicinal Cannabis User Initial Questionnaire

Today's Date _____ ©1996 Tod Mikuriya Draft 9 9-12

Identifying Data

Last name_____, **First name** _____ **Middle Initial** __
Address _____ **City** _____ **State** ____ **Zip** _____
Res Ph _____-_____-_____ **Work Ph** _____-_____-_____ **ext**____ **Fax** _____-_____-____
Birthdate (MMDDYY)_____ **SS#**___-__-____ **Sex M_ F_ Ethnic Wh_B_Hisp_Or_ NatAm_**
Other ____ **Education** _____**Occupation(s)**_____ **Unemployed_ Disabled_**
Marital Status: Single_ Mar_ Sep_ Div_ W_ Living situation:_ Alone _ Couple_ Group_
Apartment_ House_ Institution_ Homeless_
Health Insurance None_ Medicaid_ Medicare_ Workers Compensation_ Other health plan._
(specify)_____ **ID Number** _____ **GroupNumber**_____
Address _____ **City** _____ **State** ___ **Zip** ____ **Phone** ___-___-____x ____
Referred by: Self _ Name_____ **Institution** _____
Address _____ **City** _____ **State** __ **Zip**____
Phone ___-___-____x _____ **Fax** ___-___-____ **Pager** ___-___-____

Chief Complaint(s) circle and rank in importance: example: AIDS related illness 1 anorexia 2

1. Alcoholism	14. Cron's disease	30. Chronic Fatigue Syndrome	44. Tourette's syndrome	58. Other Pain (specify source)____
2. Alcohol Abuse	15. Gastritis	31. Epilepsy	45. Glaucoma	59. External Use ___
3. Sedative/Opiate Habit	16. Pancreatitis	32. Delirium Tremens	46. Menstrual cramps	60. Drug Side Effect control (specify)___
4. Cocaine or Speed Habit	17. Hepatitis	33. Dementia	47. Labor pains	61. Decrease Use of Other Drugs (specify)_____
5. Nicotine Habit	18. Peptic Ulcer	34. Multiple Sclerosis	48. Migraine	62. Substitute for Other Drugs (specify) _____
6. AIDS related illness	19. Antibiotic	35. Huntington's Chorea	49. Meniere's Disease	63. Other _____
7. Cancer & cancer Rx	20. Asthma	36. Cerebral Palsy	50. Hypertension	
8. Anorexia	21. Sinusitis	37. Brain Trauma	51. Itching	
9. Nausea	22. Cough	38. Spinal Cord Injury	52. Hiccough	
10. Vomiting	23. Anxiety	39. Muscle spasm	53. Arthritis	
11. Diarrhea	24. Panic attacks	40. Parkinson's disease	54. Carpal Tunnel Syndrome	
12. Irritable bowel	25. Insomnia	41. Tremor	55. Lupus, scleroderma	
13. Colitis	26. Mania	42. Periphal neuropathy	56. Amyloidosis	
	27. Depression	43. Tic doloroux	57. Conjunctivitis	
	28. Lethargy			
	29. Weakness			

Chief Complaint _____ ICD9-CM Diagnoses _____ _____ _____
History ofPresent Illness: **(date of onset, course)** _____
PastMedicalHistory: **(Allergies & adverse drug reactions):**_____
_____
Family Medical History:_____
_____
Social History: _____ **Drug law arrests/convictions: None_ Yes (specify)** _____
Cannabis type preferred: **Sinsemilla_ Mexican_ Hashish_ No preference Other**_____
Age or date Use Begun:_____ Marinol ®**(dronabinol) 2.5 mg _ 5 mg _ 10 mg _ result (+)_ (0)_ (-)_**
Route: **Oral_ Inhaled: Joint_ Pipe_ Water Pipe_ Vaporizer_ Other (specify):**_____
Frequency: **Monthly_ Weekly_ Semiweekly_ Daily_ Twice a day_ 3 x a day _ 4 x a day _more _**
Other drugs using- **Rx and Over the Counter**_____
Has your physician discussed your use of cannabis with you? **Yes _ No _ Discussed any non prescribed psychoactive drugs? (including alcohol and tobacco) Yes _ No _ Remarks** _____
Completed by:_____

INITIAL INTAKE FORM lists conditions treated with Cannabis according to the pre-prohibition literature, plus conditions reported by California patients.

METHODOLOGY

Identifying Alcoholism

The initial consultation (20 minutes) provided multiple opportunities to identify alcoholism as a problem for which treatment with cannabis might be appropriate. The intake form asked patients to state their reason for contacting the doctor, and enabled them to prioritize their present illnesses and describe the course of treatment to date. The form also asked patients to identify any non-prescribed psychoactive drugs they were taking (including alcohol), and invited remarks. A specific question concerned injuries incurred "while or after consuming alcohol." My reading of patients' medical records provided an additional opportunity to identify alcohol abuse, as did the taking of a verbal history.

Evaluating Efficacy

At follow-up visits (typically at 12-month intervals) patients were asked to list the conditions they had been treating with cannabis and to evaluate their status as "stable," "improved," or "worse." Patients were asked to evaluate the efficacy of cannabis (five choices from "very effective to "ineffectual") and to describe any adverse events. Patients were also asked to describe any changes in their "living and employment situation," and if so, to elaborate. The question about use of non-prescribed psychoactive drugs, including alcohol, was repeated. Comparison of responses in a given patient's initial and follow-up questionnaires enabled us to assess the utility of cannabis as an alternative to alcohol.

Patient Background

Gieringer (op cit) notes that "Many patients who find marijuana helpful for otherwise intractable complaints report that their physicians are fearful of recommending it, either because of ignorance about medical cannabis, or because they fear federal punishment or other sanctions. This is especially true in regions where the use of marijuana is less familiar and accepted." The patients whose records form the basis for this study were all seen in ad hoc settings arranged by local cannabis clubs —72 in rural counties of Northern California, 4 in San Francisco. They form a special but not unique subset, having intentionally sought out a physician whose clinical use of cannabis—and confidence in its versatility and relative safety— was extensive and well known in their communities.

A majority of the patients identified themselves as blue-collar workers: carpenter (5), construction (3), laborer (3), waitress (3), truck driver (3),

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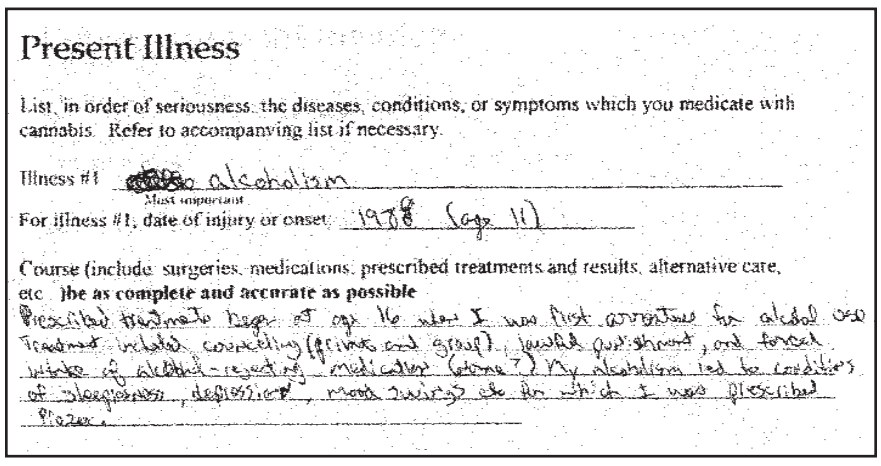
Cannabis v. Alcohol *from previous page*



Present Illness

List, in order of seriousness, the diseases, conditions, or symptoms which you medicate with cannabis. Refer to accompanying list if necessary.

Illness #1: alcoholism
Most important

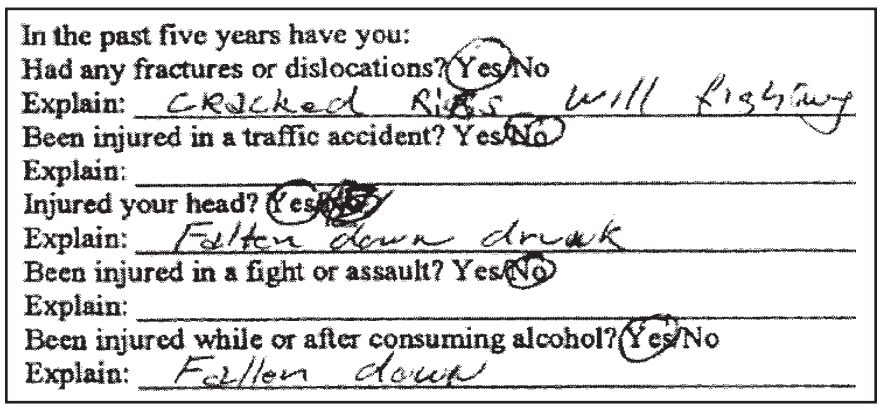
For illness #1, date of injury or onset: 1998 (age 16)

Course (include: surgeries, medications, prescribed treatments and results, alternative care, etc...)**be as complete and accurate as possible**
Prescribed treatment began at age 16 when I was first arrested for alcohol use. Treatment included counseling (private and group), jail, out-patient, and forced visits of alcohol-reacting medication (what?) My alcoholism led to conditions of sleeplessness, depression, mood swings etc for which I was prescribed Prozac.

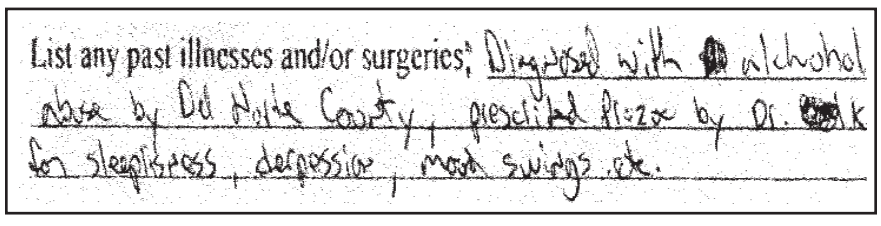
Illness #2: Insomnia
Next most important

For illness #2, date of injury or onset: 15+ years

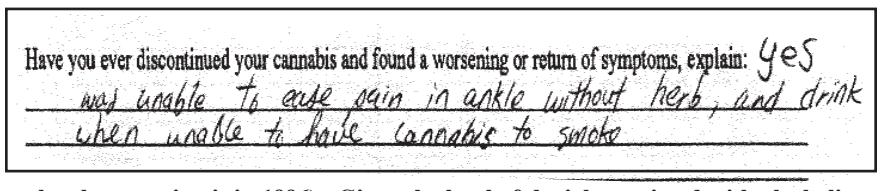
Course (include: surgeries, medications, prescribed treatments and results, alternative care, etc...)**be as complete and accurate as possible**:
I have trouble sleeping so I tended to use alcohol for a long time to allow me to finally go to sleep. (Otherwise lay awake and go crazy with fears, anger,



In the past five years have you:
Had any fractures or dislocations? Yes/No
Explain: Cracked Ribs, Will Fighting
Been injured in a traffic accident? Yes/No
Explain:
Injured your head? Yes/No
Explain: Fallen down drunk
Been injured in a fight or assault? Yes/No
Explain:
Been injured while or after consuming alcohol? Yes/No
Explain: Fallen down



List any past illnesses and/or surgeries: Diagnosed with alcohol abuse by Del Norte County, prescribed Prozac by Dr. [redacted] for sleeplessness, depression, mood swings etc.



Have you ever discontinued your cannabis and found a worsening or return of symptoms, explain: yes
was unable to ease pain in ankle without herb, and drink when unable to have cannabis to smoke

QUESTIONS ELICITING RESPONSES RELATED TO ALCOHOL USE appear throughout the questionnaire (which has undergone several refinements since the author began using it in 1996). Given the level of denial associated with alcoholism, many problem drinkers don't list it foremost —or at all— among their present illnesses.

fisherman (3), heavy equipment operator (3), painter (2), contractor (2) cook (2), welder (2), logger (2), timber faller, seaman, hardwood floor installer, bartender, building supplies, house caretaker, ranch hand, concrete pump operator, cable installer, silversmith, stone mason, boatwright, auto detailer, tree service, handyman, cashier, nurseryman, glazier, gold miner, carpet layer, carpenter's apprentice, landscaper, river guide, screenprinter, glassblower.

Eleven were unemployed or didn't list an occupation; four were disabled, two retired, and two patients defined themselves as mothers. Others were in sales (5), musicians (5), clerical workers (3), paralegal, teacher, actor, actress, artist, sound engineer, computer technician.

Eighty-two of the patients were men.

Patients' ages ranged from 20 to 69. Twenty-nine were in their twenties; 16 in their thirties; 24 in their forties; 20 in their fifties; three in their sixties.

Exactly half —46 patients— had taken some college courses, but only four had college degrees. Five did not complete high school.

Thirteen were veterans, all branches of the Armed Forces being represented.

All but six—five native-Americans, one African-American— were Caucasian.

Slightly more than half (49) reported being raised by at least one addict/alcoholic parent.

Prioritizing Alcoholism

Fifty-seven of the patients identified alcoholism or cirrhosis of the liver as their primary medical problem. Secondary problems reported by this group were Depression (15), Pain (14), Arthritis (7), PTSD (6), Insomnia (6), Cramps (4) Hepatitis C (4) Anxiety (3), Stress (2), gastritis, and ADHD.

Thirty-one patients identified themselves as alcohol abusers, but reported other problems as primary: Pain (12), Depression (8), Headache (4), Bipolar Disorder (2) Anxiety (2), Arthritis (2), Asthma (2) Spinal Cord Injury/Disease (2), Paraplegia, PTSD, Crushed skull, Aneurysms aggravated by stress, ADHD, Multiple broken bones.

Eighteen patients reported having been injured while or after drinking heavily.

Fourteen had incurred legal problems or been ordered into rehab programs.

Cannabis Use/ Awareness of Medicinal Effect

Patients were asked when they started using cannabis and when they realized it exerted a medicinal effect.

Three reported first using at age 9 or younger; 61 between ages 10 and 19; nine began using in their 20s; three in their 30s; six in their 40s; two at age 50; and one at age 65.

Twenty-four patients reported realizing immediately upon using cannabis that it exerted a beneficial medical effect. Some of their responses still seem to reflect their relief at the time.

• "In 1980 I had quit drinking for a month. My niece asked me if I ever tried marijuana to calm me down. So I tried it and it worked like a miracle."

• "Helped pain very much! Helped sleep —excellent."

Thirty-five patients answered ambiguously with respect to time —"When realized preferred to alcohol," for example, or, "when I smoked when suffering."

Seven reported becoming aware of medical effect within a year of using cannabis. Ten became aware within one to five years.

Three became aware of medical effect 12-15 years after first using. Ten became aware between 20 and 30 years after first using. All but one had resumed using cannabis after years of abstinence.

Efficacy

As could be expected among patients seeking physician approval to treat alcoholism with cannabis, all reported that they'd found it "very effective" (41) or "effective" (38).

Efficacy was inferred from other responses on seven questionnaires. Two patients did not make follow-up visits.

Nine patients reported that they practiced total abstinence from alcohol and attributed their success to cannabis. Their years in sobriety: 19, 18, 16, 10, 7, 6, 4 (2), and 2.

Twenty-nine patients reported a return of symptoms when cannabis was discontinued. Typical comments:

• "I quit using cannabis while I was in the army and my drinking doubled. I was also involved in several violent incidents due to alcohol."

Use of Other Drugs

Patients were asked to list other drugs —prescribed, over-the-counter, and herbal— that they were currently using or had used in the past to treat their illnesses. Most common of the prescription drugs were SSRIs (31), opiates (23) NSAIDs (18) disulfaram (15) and Ritalin (8).

Delivery Systems

Seventy-eight patients smoked joints —the average amount being one joint a day (assuming 3.5 joints per 1/8 ounce of high-quality marijuana). Twelve patients reported using a pipe, and three owned vaporizers. All were strongly advised that smoking involves an assault on the lungs, and that vaporization is a safer method of inhaling cannabinoids.

OBSERVATIONS

Alcoholic Parents

That a slight majority of patients (51) reported being raised by at least one alcoholic parent was not surprising. The children of alcoholics enter adulthood with two strikes. They have endured direct emotional abuse and/or abandonment by parent(s); and they lack role models for coping with uncomfortable feelings other than by inebriation. It is to be expected that many, when encountering problems early in life, are treated with, or seek out, mind-altering drugs.

Cannabis for Analgesia

The large number of patients using cannabis for pain relief (28) reflects the high percentage of blue-collar workers who suffer musculoskeletal injury during their careers. As expressed by a carpenter, "Nobody gets to age 40 in my business without a bad back." Nurses who must lift patients onto gurneys, farmworkers, desk-bound clerical workers, and many others are also prone to chronic back and neck pain.

Fights and accidents — vehicular, sports- and job-related— also create chronic pain patients, many of whom self-medicate with alcohol.

Eighteen patients reported having been injured while or after drinking heavily. This comment by Jamie R., a 26-year-old truck driver, describes a typical chain-reaction of alcohol-induced trouble: "Injured in a fight after consuming alcohol, resulted in staph infection of right knuckle, minor surgery and four days in hospital." Injuries suffered while drunk add to pain and the need for relief by alcohol —or a less destructive alternative.

Injuries suffered while drunk add to pain and the need for relief by alcohol —or a less destructive alternative.

A total of 26 patients reported using cannabis for both pain relief and as an alternative to alcohol. Mike G., a 47-year old landscaper who was run over by a vehicle at age 5, requiring multiple surgeries and leaving him with pins in his right ankle, first used cannabis at age16 and appreciated its benign side-effect profile: "Given pain pills for my right ankle, I got too drowsy. Smoked herb to relieve pain." And when he had to discontinue cannabis use, "was unable to ease pain in ankle without herb, and drink when unable to have cannabis to smoke."

Cannabis for Mood Disorders

Twenty-three patients reported using cannabis to treat depression —39 if the category is expanded to include anxiety, stress, and PTSD— and their comments frequently touched on the negative synergies between mood disorders and alcoholism.

• Wendy S., a 44-year-old paralegal, suffering from depression, alcoholism, and PMS noted simply, "Alcohol causes more depression." When she does not have access to cannabis, "Alcohol consumpion increases and so does depression." At her initial visit she reported consuming 5-10 drinks/day. At a follow-up (16 months) she had reduced her consumption to week-ends.

• Albert G., a 33-year-old river guide (and decorated Army vet) put it this way: "I have had a problem with violence and alcohol for a long time and I have a rap sheet to prove it. None of the problems occurred while using cannabis. Not only does cannabis prevent my violent tendencies, but it also helps keep me from drinking." On his follow-up visit

continued on next page

Cannabis v. Alcohol *from previous page*

Cannabis type preferred: Sinsemilla X Mexican _ Haskish _ No preference Other _____
Age or date Use Begun: 1987 Was your past use social? Yes X No _
When and how did you discover that cannabis helped your symptoms? Pre Cancer th
Alcohol

Other drugs used now

Prescribed and over the counter medicines and herbs used to treat condition(s) for which cannabis is used
Vikadin, ~~[illegible]~~ Soma
-gets

Non-medical psychoactive drugs, include: alcohol/tobacco/opiates/cocaine/LSD/Ecstasy/etc...
Alcohol & Tobacco, Valume
Include how often or how much used

Non Medical psychoactive: Alcohol _ Nicotine √ Opiate _ Cocaine _ Amphetamine _ LSD _ Ecsta
Remarks ALCOHOL WHEN NO CANNABIS

Use this space for anything else that you think the doctor should be aware of:
I find the use of CANNABIS TO BE Beneficial in relieving pain in ankle, and to keep from drinking alot.

Is there any other information that you think the doctor should be aware of?
cannabis has been effective in decreasing my alcohol consumption to a couple of drinks (2-3) per week.
This has also increased stability at home where I live with my (still practicing) alcoholic father.

OPEN-ENDED REQUEST for additional information elicits frequent references to alcohol-related problems (see answers above and bottom of page).

(12 months) Albert reported improved communication with family members and fewer problems relating to other people. His alcohol consumption had decreased from 36 drinks/week to zero (one month of sobriety).

• Carol G. presented initially at age 35 as homeless and unemployed, suffering "severe depression. Anxiety. Pain." Her problem with alcohol was inferred from her response concerning non-medical-psychoactive drug use: "I drink and smoke too much —started when I couldn't get marijuana."

Carol had shyly requested a recommendation for cannabis from a Humboldt County physician but, as she recounted, "I'm paranoid and local Drs are scared, too. They gave me paxil & stop smoking pamphlet."

At a follow-up visit (14 months) Carol reported a change in circumstance: "Now have a room. But am on G.R. and am paying too much." She was still using alcohol "a little. I'm doing good dealing with not drinking. Being able to medicate with cannabis has helped a lot." Eighteen months later the pattern hadn't changed: "Alcohol several times/week. Depends on if I have cannabis, stress still triggers."

Fewer Adverse Effects

Patients made negative comments with respect to the efficacy of their prescribed analgesics and anti-depressants (22), side-effects (26), and cost (11) —not surprising, perhaps, in a cohort seeking an herbal alternative.

• Lance B. presented as a 41-year-old alcoholic also suffering from arthritis, pain from knee- and ankle surgeries, and depression, for which he had been prescribed Librium, Valium, Buspar, Welbutrin, Effexor, Zoloft, and Depakote.over the years; "No help!," he wrote bluntly. On his return visit (one year) he reported "few relapses" and that he was able to take some classes.

• The dulling effects of Vicodin and other opiates were mentioned by seven patients. As Harvey B. put it, "When I can get Vicodin it helps the pain but I don't like being that dopey." Clarence S., whose skull was badly damaged in an accident, also appreciated the pain relief provided by opiates, but asserted, "Opiates make me paranoid and mean."

• Alex A., who was diagnosed with ADHD in ninth grade, touches on some recurring themes in describing the treatment of his primary illness: "I was prescribed Ritalin and Zoloft. The Ritalin helped me concentrate slightly but caused me to be up all night. The Zoloft made me sick to my stomach and never relieved my stress or depression. I have never been prescribed anything for my insomnia but I usually have to drink some liquor to get to sleep. I think that is a bad thing as I have now begun to drink excessive amounts of whisky, which has really started to affect my stomach." Alex first used cannabis at age 19 and became aware of benefits immediately. "I found myself running to the refrigerator and then sleeping better than I had for years." At age 21 he fears permanent damage. "From drinking (I believe) my stomach has been altered, along with my appetite… I cannot really eat that much and feel malnourished and weaker than a 21-year-old should. My joints ache constantly and I am not as strong as I used to be. I also fear that I will become or am an alcoholic and I do not want to see myself turn into my dad."

At his follow-up visit (12 months) Alex reported cannabis to be "very effective." He was employed, "not partying," doing well socially, and trying to give up cigarettes.

Drug Interactions

No negative interactions between cannabis and other drugs were reported. Several patients (3) indicated that cannabis had a welcome amplifying effect on the efficacy of prescription and OTC medications. "I hurt a lot more without cannabis and can't function as well," reported Liz J. "It seems to relax me so the medicines work better and faster. Additionally, cannabis is natural, and all these other drugs —Vicodin, Soma, Aleve, Librium, Baclofen, have lots of side effects."

As cannabis comes into wider use in California and elsewhere, it is important that its interactions with other medications be studied and publicized. Cannabis may also have an amplifying effect on alcohol, enabling some patients to achieve a desired level of inhibition-reduction or euphoria while drinking significantly less.

Defining Success

The harm-reduction approach to alcoholism is based on the recognition that for some patients, total abstinence has been an unattainable goal. Success is not defined as the achievement of perpetual sobriety. A treatment may be deemed helpful if it enables a patient to reduce the frequency and quantity of alcohol consumption; if drunken episodes and/or blackouts are reduced; if success in the workplace can be achieved; if specific problems induced by alcohol (suspended driver's license, for example) can be resolved; if ineffective or toxic drugs can be avoided.

As noted, all of the patients in this study were seeking physician's approval to use cannabis medicinally —a built-in bias that explains the very high level of efficacy reported. However, the majority were using cannabis for other conditions as well, and would have qualified for an approval letter whether or not they reported efficacy with respect to alcoholism.

Although medicinal use of cannabis by alcoholics can be dismissed as "just one drug replacing another," lives mediated by cannabis and alcohol tend to run very different courses. Even if use is daily, cannabis replacing alcohol (or other addictive, toxic drugs) reduces harm because of its relatively benign side-effect profile. Cannabis is not associated with car crashes; it does not damage the liver, the esophagus, the spleen, the digestive tract. The chronic alcohol-inebriation-withdrawal cycle ceases with successful cannabis substitution. Sleep and appetite are restored, ability to focus and concentrate is enhanced, energy and activity levels are improved, pain and muscle spasms are relieved. Family and social relationships can be sustained as pursuit of long-term goals ends the cycle of crisis and apology.

Carl S., a 42 year old journeyman carpenter, is a success story from a harm-reduction perspective. At his initial visit he defined his problem as "intermittent explosive disorder," for which he had been prescribed Lithium. Although drinking eight beers/day, he reported "Cannabis has allowed me to just drink beer when I used to blackout drink vodka and tequila." By the time of a follow-up

continued on next page

Other medications also being used.

Prescribed and Over the Counter to treat condition(s) for which cannabis is used.
paxil

Non Medical psychoactive: Alcohol √ Nicotine √ Opiate _ Cocaine _ Amphetamine _ LSD _ Ecstasy _
Remarks I drink & smoke too much - started when I couldn't get marijuana

Has your physician discussed your use of cannabis with you?
Yes _ No √ Remarks: I'm paranoid and local Drs are scared too

Discussed any non prescribed psychoactive drugs? (including alcohol and tobacco) Yes √ No
Remarks they gave me paxil & stop smoking pamplet

Use this space for anything else that you think the doctor should be aware of:
Cannabis in the evening makes me calmer with my kids, drink less alcohol and sleep through the night without waking angry or anxious.

Cannabis v. Alcohol *from previous page*

visit (12 months), Carl had been sober for four months. He also reported "anger outbreaks less severe, able to complete projects," and, poignantly, "paranoia is now mostly realism." He plans to put his technical skill to use in designing a vaporizer.

The Doctor-Patient Relationship

As a certified addiction specialist I have supervised both inpatient and outpatient treatment for thousands of patients since 1969. In the traditional alcoholism medical-treatment model, the physician is an authority figure to a patient whose life has spun out of control. The patient enters under coercive circumstances, frequently under court order, with physiologies in toxic disarray. Transference dynamics cast the physician into a parental role, producing the usual parent-child confl icts. After detoxification, when cognition has returned from the confusional state of withdrawal, the patient leaves —usually with powers of denial intact. Follow-up outpatient treatment is oriented to AA and/or pharmacologic substitutes.

Treating alcoholism by cannabis substitution creates a different doctor-patient relationship.

Treating alcoholism by cannabis substitution creates a different doctor-patient relationship. Patients seek out the physician to confer legitimacy on what they are doing or are about to do. My most important service is to end their criminal status —Aeschalapian protection from the criminal justice system— which often brings an expression of relief. An alliance is created that promotes candor and trust. The physician is permitted to act as a coach —an enabler in a positive sense.

As enumerated by patients, the benefits can be profound: self-respect is enhanced; family and community relationships improve; a sense of social alienation diminishes. A recurrent theme at follow-up visits is the developing sense of freedom as cannabis use replaces the intoxication-withdrawal-recovery cycle —freedom to look into the future and plan instead of being mired in a dysfunctional past and present; freedom from crisis and distraction, making possible pursuit of long-term goals that include family and community.

Re: Alcoholics Anonymous

Although nine patients made voluntary reference to attending 12-step meetings (three presently, six in the past), it is likely that many more actually tried the 12-step program —but the question was not posed on the intake form. A future study should examine the relationship between cannabis-only users and Alcoholics Anonymous.

At AA meetings, cannabis use is considered a violation of sobriety. This puts cannabis-only users in a bind. Those who attend meetings can't practice the "rigorous honesty" that AA considers essential to recovery; and those who avoid meetings are denied support and encouragement that might help them to stay sober. Support-group meetings at which cannabis-only users are welcome would be a positive development.

Frank R., first seen at age 29, was diagnosed as an alcoholic in 1987 and began attending AA meetings, which he found helpful although he could not achieve sustained sobriety. In 1998, after realizing that cannabis reduced his cravings for alcohol, he received approval to use it. At a follow-up in November '99 he reported, "Have stopped drinking for the first time in many years. I have not taken a drink of alcohol in 14 months. I attribute some credit for this to daily use of cannabis. My life has improved with this treatment."

Frank R. was seen again in April '01 and reported, "I continue to maintain sobriety regarding alcohol. Have not had a drink for 2 1/2 years. I drank alcohol heavy for about 10 years, and had difficulty stopping drinking and staying stopped until I began this treatment. Pain symptoms from back spasms/scoliosis also better."

Factors in Drug of Choice

British psychiatrist G. Morris Carstairs spent 1951 in a large village in northern India and reported on the two highest castes, Rajput and Brahmin, and their traditional intoxicants of choice — alcohol and cannabis, respectively. The Rajputs were the warriors and governors; they consumed a potent distilled alcohol called daru. The Brahmins were the religious leaders; they were vegetarians and drank a cannabis infusion called bhang.

"By virtue of their role as warriors, the Rajputs were accorded certain privileged relaxations of the orthodox Hindu rules," writes Carstairs, "in particular, those prohibiting the use of force, the taking of life, the eating of meat and drinking of wine." The Rajputs viewed the daru-inspired release of emotions —notably sexual and aggressive impulses— as admirable. Rajput lore, as shared with Carstairs, glorified sexual and military conquests.

The priestly Brahmins, on the other hand, "were quite unanimous in reviling daru and all those who indulged in it. They described it as foul, polluting, carnal and destructive to that spark of Godhead which every man carries within him." Bhang, a Brahmin told Carstairs, "gives good bhakti." He defined bhakti as "emptying the mind of all worldly distractions and thinking only of God."The Brahmin emphasis on self-denial includes "the avoidance of anger and or any other unseemly expression of personal feelings; abstinence from meat and alcohol is a prime essential." Carstairs's stated goal was to understand how the Brahmins could rationalize intoxicant use. He concluded:

"There are alternative ways of dealing with sexual and aggressive impulses besides repressing them and then 'blowing them off' in drinking bouts in which the superego is temporary dissolved in alcohol. The way which the Brahmins have selected consists in a playing down of all interpersonal relationships in obedience to a common, impersonal set of rules of Right Behavior. Not only feelings but also appetites are played down, as impediments to the one supreme end of union with God... Whereas the Rajput in his drinking bout knows that he is taking a holiday from his sober concerns, the Brahmin thinks of his intoxication with bhang as a flight not from but toward a more profound contact with reality."

Prohibition of marijuana, the intense advertising of alcohol, and the widespread availability of bars encourage the adoption of alcohol as a drug of choice among U.S. adolescents.

Two aspects of Carstair's report resonate strongly with my own observations:

• The disinhibition achieved via alcohol is the Rajput kind —a flight from reality, becoming "blotto"— whereas the disinhibition achieved via cannabis is the result of focused or amplified contemplation.

• "Drug of choice" is strongly influenced by social and cultural factors, and, once determined, becomes a defining element of individual self-image, not easy —but possible— to change in adulthood. Prohibition of marijuana, the intense advertising of alcohol, and the widespread availability of bars encourage the adoption of alcohol as a drug of choice among U.S. adolescents. It is likely that legal access to cannabis would result in fewer young adults adopting alcohol as their drug of choice, with positive consequences for the public health and countless individuals.

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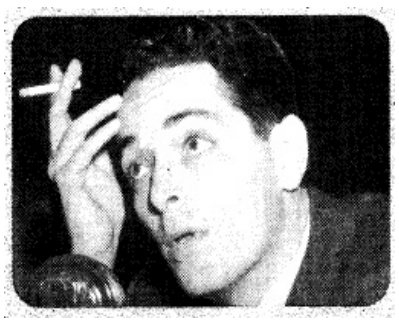
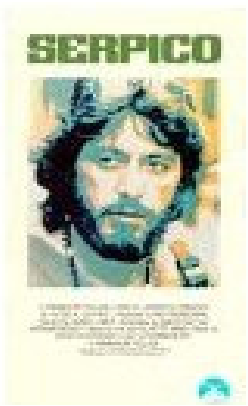
Ring Lardner, Jr. On Cannabis As A Substitute For Alcohol



Screenwriter Ring Lardner, Jr. won an Oscar in 1938 for "*Woman of the Year"* and another in 1970 for *"M*A*S*H."* His memoir "I'd Hate Myself in the Morning" (which takes its title from his line to the House Un-American Activities Committee) includes this description of his colleagues Ian Hunter and Waldo Salt:

"Ian, too, had an alcohol problem —one that, unlike mine, increased in severity to the point of debilitation. During the period when we had to come up with an episode for a half-hour television program every week, there were times when I had to perform the task by myself. On occasion, he would pull himself together and make a big effort to match what I had done single-handed. Eventually, though, he came to the conclusion that he would have to give up drinking for good. And he proceeded to do just that, first by enlisting in Alcoholics Anonymous, as he went cold turkey, then, to fortify his abstinence, by substituting marijuana for alcohol. It happened that a friend of ours, the blacklisted writer Waldo Salt, had made the same medicinal switchover. Since Ian and Waldo also shared a love of drawing, they could pool the cost of a model and spend an evening indulging in pot and art. Neither of them drank again, as far as I know.



"Some years earlier, when the film community was still disproportionately Jewish, my good friend Paul Jarrico announced a discovery. He had been wondering why a small group of his fellow screenwriters —Ian, Dalton Trumbo, Hugo Butler, Michael Wilson, and I— were such a close, cozy group. What bound us together, Paul reported, was the fact that we were all gentiles. 'Nonsense,' Ian declared, 'It's that we're all drunks.' Instantly, I knew he was right. It was by far the stronger bond."

Waldo Salt's screenwriting credits include Serpico *and* Midnight Cowboy.