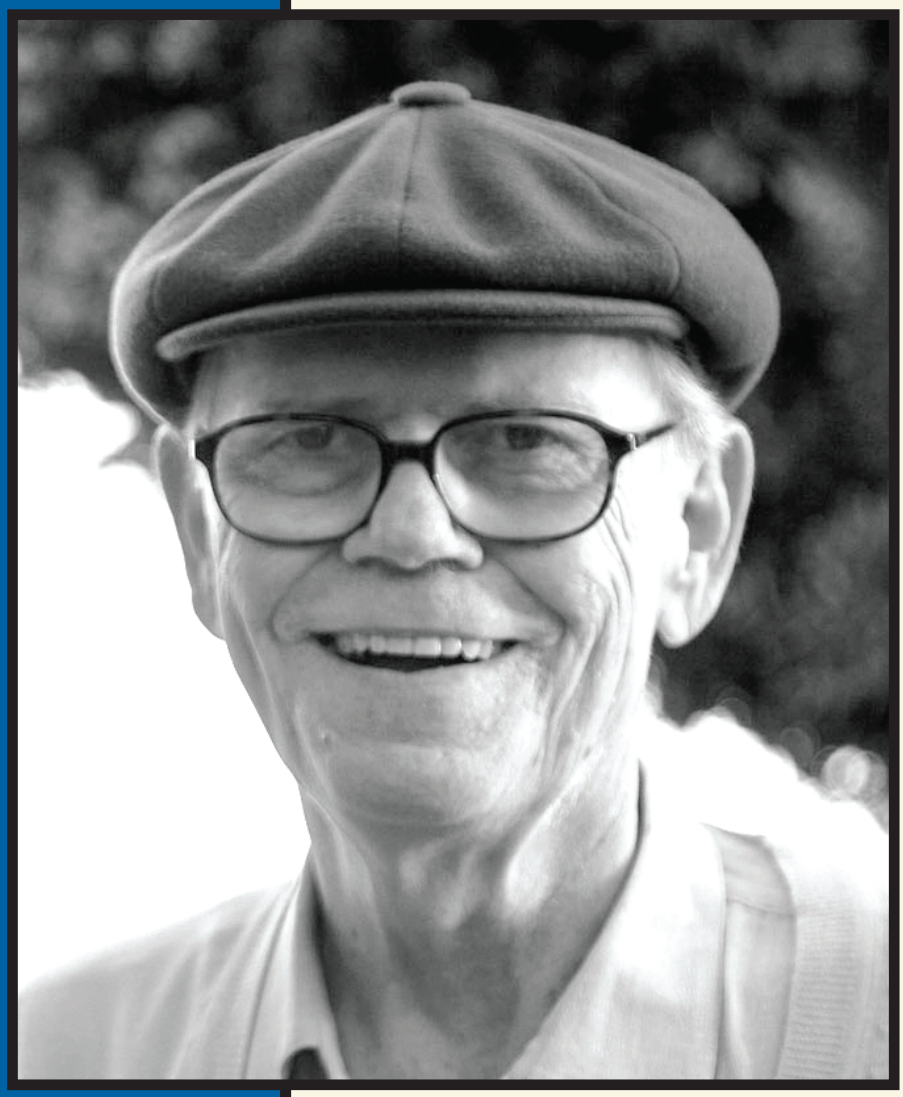
# ACUDETOX: LOST, STOLEN OR STRAYED?

## The NADA Ear Acupuncture Protocol



A *GUIDEPOINTS* SERIES OF ARTICLES

by Alex Brumbaugh



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*"Part of the problem of the practice of addiction treatment is that it is guided by research that isn't asking the right questions."*

*- Alex Brumbaugh*

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# Acudetox: Lost, Stolen or Strayed?

I have the sense that sometime in the 1980s acupuncture slipped in through the side door of the chemical dependency treatment establishment while no one was looking and made itself comfortable, as though that is where it had belonged all along.

Then, 20 years later (as though stirring from some deep trance), the people "in charge" of treatment looked around the room and said, "Who are these people? What do they want? What do they think they are doing?"

We untried (though articulate, passionate, and charismatic) pioneers of acudetox back in those early days believed with Robert Olander, Director of Chemical Health for Hennepin County, MN, that "acupuncture was going to revolutionize the way we do alcohol and drug therapy in this country." Its impact, he said was going to be equivalent to that of Alcoholics Anonymous in 1935 and the invention of methadone in 1937.

I myself - in that glorious honeymoon period - was brash enough to go so far as to suggest that acupuncture's proper role was not as a mere adjunct to chemical dependency treatment but – properly done – was the actual foundation. I wrote a book making that case (Brumbaugh, 1994).

Acudetox was sexy. It was popular with clients, the press, and the criminal justice community. It was inexpensive, easy to teach, portable, and it made possible something previously unknown: "outpatient drug-free detoxification". The harshest criticism many physicians could summon was, "Well, it probably won't do any harm."

By the early 1990s, acudetox strongholds were established throughout the country, and the National Acupuncture Detox Association (NADA) was already heralding a formidable body of research and outcome studies in a wide variety of settings demonstrating the strong efficacy of this simple, unobtrusive tool.

But those of us working on the front lines needed no clinical trials or outcome studies to affirm that this fivepoint auricular protocol offered profound and virtually peerless support in the journey of addiction recovery. "What do you put in those needles?" many of our clients asked.

*Acudetox was sexy. It was popular with clients, the press, and the criminal justice community.*

The growth and acceptance of acudetox culminated in 2002, when the Center for Substance Abuse Treatment (CSAT), the division of the United States Substance Abuse and Mental

Health Services Administration responsible for administering state block grants and other grants for substance abuse treatment – an agency which had already established that acudetox was an allowable cost under their state block grant programs - agreed to develop and publish a TIP (Treatment Improvement Protocol) devoted to acudetox.

The effort, spearheaded by CSAT's Alan Trachtenberg, MD., and given a political nudge forward by Texas Congresswoman Kay Granger, would give the "Good Housekeeping Seal of Approval" to acudetox, and would have provided comprehensive guidelines for its incorporation into chemical dependency treatment under NADA guidelines throughout the land. NADA and its trainers girded for unprecedented growth.

That was the moment – just as we were preparing to go to press with our TIP - that the chemical dependency treatment and research establishment shook itself out of its long slumber. Maybe the light the TIP shown on our work was too bright.

We will spend more time on the death of the TIP in later installments of this series. But dead it was, and within a decade, the flagship acudetox programs of the country were gone.

My personal meditation for several years has been to try and figure out how to get acupuncture back on the table and back in the treatment conversation. And I don't want to slip in through the side door again; I want to break down the front door.

This series of four articles will be on that meditation. But this meditation begs the question, "What happened? Is there a villain in our story – a particular culprit upon whom we can place blame for the failure of acupuncture to take firm root in the addiction treatment field?"

## Evidence-Based Practices

In order to get to a meaningful perspective, we need to step back and take a broader look at the entire field of substance use and addictive disorders and the problems it was facing at the turn of the 21st Century. Most striking is the wide variance among treatment programs in their philosophies, clinical approaches, and assumptions about the factors that are important for successful addiction recovery, as well as by the diversity of prisms through which addiction was being viewed – medicine, psychiatry, forensic science, psychology, spirituality, religion, holistic health, public health, social work, peerbased recovery, etc. It becomes increasingly clear that the treatment field is fragmented; it lacks a defining center.

The Wellstone/Domenici Mental Health Parity and Addiction Equity Act went into effect in January, 2011. The act is intended to improve access to addiction and mental health treatment for millions of Americans, primarily by requiring many health plans to cover addiction and mental health services on par with other health conditions. Combined with health care reform, this legislation will potentially reach the more than 20 million people who need treatment and are not getting it, and will result in an expansion in available funding for prevention, treatment, and recovery support services as Medicaid reimbursement expands.

My fear was that – in its fragmented state - the treatment field will be ill-prepared for the new scrutiny that this expansion is likely to bring.

Also of concern is the increased dominance of Evidence-Based Practices (E-BPs), the most powerful force to emerge in the treatment of addiction and substance use disorders in the early years of the 21st Century.

Arising originally from the field of medicine in the 1990s, the E-BP movement can be seen as an effort to make the treatment of substance use and addictive disorders more like a hard science, and one less based on intuition, observation, qualitative studies, and what was viewed by many "hard scientists" as folklore (e.g. spiritual support through 12-Step Programs).

Acupuncture – voodoo at best and groundless folk medicine at worst – was a direct target of this.

## *Maybe the light the TIP shown on our work was too bright.*

One towering figure inside the E-BP movement is William Miller, PhD., a researcher and professor at the University of New Mexico. Miller is one of the most widely cited scientists by "The Institute for Scientific Information." He is himself the author of two Center for Substance Abuse Treatment TIPS, one on "motivational interviewing," and the second on "brief intervention."

In a 2006 article appearing in the prestigious (and policy influencing) Journal of Substance Abuse Treatment Miller and colleagues' raised the question, "Why are substance abuse treatment programs so resistant to E-BPs?" He talks about the "natural diffusion" of E-BPs from the research community to the treatment community. He suggests however that something in that process is not flowing quite as "naturally" as it ought. Programs cling to the old ways, the ineffective, non-E-BP ways.

He also talks about levels or standards of efficacy. The gold standard of E-BPs is the clinical trial: double-blind replicable research studies. E-BPs are also established by the consensus of professional people working in the field. (This is what comprises the TIPS of the Center for Substance Abuse Treatment.)

On lower levels of efficacy there are what Miller calls "unevaluated" treatment methods for which there has been little or no research and whose efficacy, therefore, is not known. That means that there are interventions that nobody knows anything about because the professional scientific researchers haven't studied them yet.

Next come "disconfirmed" treatment approaches. Some research has been done on these approaches, but they have been – in Miller's words – "found wanting."

And finally we have treatment methods that have a long history of negative findings in clinical trials yet continue in widespread use. "For example," Miller writes, "many substance abuse programs continue to use educational lectures and films as a standard component of treatment, unaware of dozens of clinical trials showing no impact of such didactic approaches."

*It is difficult to estimate the extent of damage to our field of such a conclusion drawn by one of the most highly respected researchers of our time in one of the most prestigious research journals.*

To provide evidence for this stunning assertion (coming as it does from a person whose primary profession is teaching) Miller cites two sources. One suggests that educational strategies used to educate physicians in CEU classes are comparable to teaching cocaine addicts about dopamine and mechanisms of craving. The second source is a chapter Miller himself wrote for the 2003 Handbook of Alcoholism Treatment Approaches. It lists new at Amazon at $95.00.

Miller continues erroneously, "Similarly, controlled trials have shown little or no beneficial impact on substance use outcomes from interventions such as acupuncture …" It is difficult to estimate the extent of damage to our field of such a conclusion drawn by one of the most highly respected researchers of our time in one of the most prestigous research journals.

In the next article in this series, we will examine Miller's sources for this damaging assertion. We will not only find that the assertion is blatantly undocumented by his source material, but more important, we will discover a fundamental and fatal flaw in the larger body of chemical dependence research of the past fifty years, which has in general done a profound disservice to our work.

*See Page 22 for references to this article.*

# Discrediting Acupunture in Addiction Treatment Research

In the first installment of this series, we reported the rejection of the efficacy of acupuncture in the treatment of substance use disorders by substance abuse research scholar, Dr. William Miller, who wrote: "controlled trials have shown little or no beneficial impact on substance use outcomes from interventions such as acupuncture…" The statement appears in a 2006 article published by the policy-influencing Journal of Substance Abuse Treatment (JSAT).

In reading such a sweeping and general discrediting of our work in a scholarly journal like JSAT, one would expect a list of citations to document the conclusion. In Miller's article, however, there is only one citation: another article that he himself wrote (Miller et.al. 2003), appearing in a book he also co-edited called Handbook of Alcoholism Treatment Approaches: Effective Alternatives.

The indictment against acupuncture in the JSAT article is – at least in part – fraudulent on the surface, because the claim made by Miller is that "controlled trials have shown little or no beneficial impact on substance use outcomes from interventions such as acupuncture. . ." The references cited to substantiate this assertion, however, are concerned with the treatment of alcohol only, not with research on the treatment of other substances for which acupuncture has been widely studied.

We find deeper flaws when we take an in-depth look at the sources and methods Miller uses in the cited article that set the standards he uses for judging acupuncture's lack of efficacy involving any substance use outcomes.

In the JSAT article, Miller describes a process he has been engaged in since the 1970s reviewing alcohol treatment studies and summarizing their findings for the treatment community. By 1980, Miller and colleagues had considered 600 studies (Miller and Hester, 1980). They then began to focus exclusively on clinical trials, and developed an elaborate matrix for assigning "box scores" to each modality studied based on a variety of factors such as cost-effectiveness, quality of study design, and the methodology of the studies– the latter using 11 quality rating scales. By 2000, the group had identified about 400 studies that met their strict criteria.

*The list Miller produced using this confounding method reveals some interesting things. More important, from our point of view, is that acupuncture doesn't rank poorly at all!*

The end result of this daunting project was the development of a ranked list – based on their efficacy – of 48 interventions for treating alcohol problems. Miller describes (2003, p 17-18) the ranking criteria as follows (I quote him literally to demonstrate his statistical dexterity):

> Cumulative Evidence Score (CES). The CES is figured in this way. For each study, the Methodological Quality Score is multiplied by the Outcome Logic Score. Then [we] added up all these scores for a particular modality. So the CES is a function of the number of studies, the scientific rigor of each study, and the outcomes for a treatment within each study.
>
> Mean Methodological Quotient Score. This is the average score of the scientific rigor of each study in a particular modality. Scores can range from 0 to 17.
>
> Mean Severity of Treatment Population. This reflects the average of how severely dependent the population studied was. Scores range from 1 (less severe alcohol related problems and dependence) to 4 (severe alcohol dependence).
>
> % Excellent. This is the percent of studies in each treatment category that had high Methodological Quotient Scores (>13 on scale of 1-17).

The list Miller produced using this confounding method reveals some interesting things. More important, from our point of view, is that acupuncture doesn't rank poorly at all! On a scale of 1 to 48, it ranks 17th. Thirty-one modalities are ranked lower, including interventions such as Client-Centered Counseling, Stress Management, Group Process Psychotherapy, Relapse Prevention, and Twelve-Step facilitation.

Miller states in the narrative (ibid. p 35), "Positive but isolated studies have been reported for acupuncture…" He cites three (Bullock et.al. 1987, Bullock, et al 1989, and Worner et al, 1992), the first two of which reported positive results. They were landmark studies that bolstered our work by showing highly successful outcomes for homeless, recidivist, alcoholic men in a Hennepin County, Minnesota detox program (the second of these studies warranted publication in the prestigious Journal Lancet). The third study cited by Worner was an unsuccessful attempt to replicate the two Bullock studies using different sham acupuncture points for the controls.

The single most important question, from the standpoint of both research and researcher integrity, is, how did Miller arrive from "Positive but isolated studies have been reported for acupuncture…" in his cited source material to "controlled trials have shown little or no beneficial impact on substance use outcomes from interventions such as acupuncture …"? Is it the result of a clerical error? An editorial slip on the part of JSAT? Is Miller held in such esteem by such journals that his citations are regarded as valid without any verification? Or is there an unconscious bias on Miller's part against acupuncture that caused a lapse in objectivity? Is he among those research scientists who feel it their self-appointed duty to debunk something that they neither understand nor can explain?

The answer is lost, because there is no formal mechanism within the research establishment

 

that provides for questioning the veracity of unsupported allegations against reputable scholars publishing in mainstream journals.

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That research establishment is an increasingly closed society, having folded into its ranks the pharmaceutical industry and the National Institute on Drug Abuse (NIDA – the primary research funding agency of the Federal Government) to a degree that the question of what strategies are effective to treat acute withdrawal and other acute symptoms of addiction and substance use is not open to further research. "Drug-free detox" (treating acute withdrawal without the use of drugs) is seen as an oxymoron, a contradiction in terms.

This collusion within the research community – in the view of one anonymous observer – resulted in the termination in of the Center for Substance Abuse Treatment's (CSAT) "Treatment Improvement Protocol" (TIP) on acupuncture in 2002, just as it was about to be published. According to that observer, NIDA influenced CSAT to abandon the TIP in order that the U.S. government not be viewed as in any way endorsing "unscientific" strategies such as "folk medicine," or likely any other strategies that would provide alternatives to drug replacement therapies in the treatment of acute symptoms of addiction.

The current establishment consensus appears to be that there is no effective amelioration of the acute symptoms of addiction without the use of other drugs, and the only really significant research agenda is to see which one(s) are more effective for which drugs delivered by what routes of administration. For many of these treatment researchers, treating drugs with drugs seems perfectly reasonable and logical.

They tailor the disease to fit their medicines in the name of "Evidence-Based Practice." These researchers resemble those scientists noted by Mukherjee (2010, p 70-71) who, mistaking their zeal for competence, ascend further and further up the isolated promontories of their own beliefs, thus drawing the blinds of circular logic around themselves.

And, not surprisingly, they are often paid for their biases. Charles Seife writes in the Scientific American (2012), "In the past few years the pharmaceutical industry has come up with many ways to funnel large sums of money … into the pockets of independent medical researchers who are doing work that bears, directly or indirectly, on the drugs these firms are making and marketing. The problem is not just with the drug companies and the researchers but with the whole system – the granting institutions, the research labs, the journals, the professional societies, and so forth. No one is providing the checks and balances necessary to avoid conflicts."

We have focused in this series on William Miller's erroneous portrayal of acupuncture outcomes in his writing. He is not alone, of course, among "research scholars" who – probably for a variety of reasons – debunk acupuncture in their published work.

But the research establishment has a far deeper systemic problem, a problem which results in profound flaws in William Miller's ranked list and the clinical trials that produced it, and indeed in the entire notion of applying "Evidence-Based Practices" to the treatment of substance use and addictive disorders. We will examine this liability of the research establishment in the next installment in this series.

*See Page 23 for references to this article.*

# The Mistaken Research Model

In this series of articles, we have been making the case that acudetox has been ill-served by addiction and substance use treatment research. But the greater reality is that addiction treatment itself has also been ill-served by this same research establishment.

According to many in the scientific community, the biggest challenge facing the field of addiction treatment is how to infuse programs with evidence-based practices (van Wormer and Thyer, 2010; Miller, et al., 2006; Miller, P., 2009), or how to infuse evidence-based treatment for substance use disorders into other venues such as primary healthcare (McCarty, et al., 2010; TRI, 2010; ONDCP, 2010).

But a far deeper problem is the field's failure to move from an acute to a chronic care model (White, et al., 2006; White, 2008; United Nations, 2010; McClellan, et al., 2006). Ironically, in fact, much of the research that has created the evidence-based practices intended to elevate addiction treatment to a level of science has been conducted from an acute rather than a chronic disease perspective. Thomas McClellan, David Lewis, and others (2000) published a landmark article presenting evidence that dependence upon alcohol and other drugs, which had been treated as an acute illness, was instead a chronic one, comparable in its etiology, course, and treatment to type 2 diabetes, hypertension, and asthma. McClellan published a follow-up article in 2002 entitled "Have We Evaluated Addiction Treatment Correctly? Implications From a Chronic Care Perspective," in which he suggests that we had been evaluating treatment the wrong way. He noted that the criteria for evaluating the effectiveness of addiction treatment are based on sustained reduction in symptoms following the termination of treatment (six or 12 months post-discharge). In other words, patients are inoculated with a treatment, and the effects are measured later. The effectiveness of other chronic disease interventions are measured by the reduction of the quantity and severity of symptoms while the patient is in treatment.

Addiction has been treated as an acute disorder by both acudetox specialists and other medical practitioners because it often presents that way in the clinical setting. "Acute disease" is a condition such as an infection, a trauma, or fracture with a brief clinical course – often less than one month. Acute conditions usually respond to treatment and the patient returns to the same state of health that existed prior to the condition.

Alcoholics and addicts often arrive for treatment in a state of withdrawal, an acute state whose symptoms include tremors, seizure, cramps, vomiting, extreme anxiety, and depression. Some of these symptoms can be severe and even life threatening. Addressing them is a natural and necessary initial clinical response. With the use of acudetox or drug replacement therapy, these symptoms can abate within five to ten days. While the patient may then appear to have achieved a state of good health, and while the presence of addictive substances in the bloodstream may have disappeared, the likelihood of a return to addictive drug use with no additional therapeutic support is frequent if not inevitable.

This is why free-standing detoxification programs are often called "revolving doors."

The researcher William White reports (2008a, p. 109) that the point at which the risk of relapse for alcoholics drops below 15% does not occur until the individual has achieved up to five or more years of sustained remission. So while addiction is a chronic condition, many are able to achieve successful recovery without further treatment if they are able to abstain from alcohol and other drug use for at least five years.

Conventional treatment programs discharge clients from 90 days up to – at most – eighteen months. Upon discharge, most programs recommend that clients go to 12-Step or comparable peer-support groups, but there is no explicit or objective understanding of the content of what that post-treatment experience will be. The implication is that *that* (whatever "that" is) is the real substance of recovery, where we hope people will learn the things that will sustain them for the long haul, the things they were ostensibly unable to learn in the treatment program. An increasing number of programs are providing aftercare or continuing care; however, such care usually amounts only to a watered-down version of the treatment venue the clients just completed. There is no consensus about what those services need to contain that will assure long term success.

In most definitions of addiction, it is a common bias that the substance to which one is addicted, and the person's relationship with it, e.g. dependency, are the most important concerns. This bias carries over to describing addiction treatment, resulting in the semantically awkward proposition that we are "treating cocaine" rather than treating addiction or – better yet – treating the person. The emphasis further carries over to how we define recovery as – by implication – the cessation of use of the substance. This has contributed to the field's difficulty in shifting from an acute (drug cessation) model to a model addressing the more clinically profound complexities of maintaining abstinence over a significant period of time.

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As William Miller has pointed out (2007), animal models of learning and neuroadaptation are sufficient to explain how human beings can fall into addiction, but what we lack is an adequate model to explain the kind of recovery that occurs in treatment and in Alcoholics Anonymous and treatment programs. As a result, the treatment field lacks a cogent definition of recovery (Betty Ford Institute Consensus Panel, 2007; Laudet, 2007; White, 2007).

In summary, those scientific studies that have produced the evidence-based practices and have frequently excluded acupuncture and acudetox from the continuum of care for addiction were based on an incorrect model, a model that did not accurately evaluate the interventions and practices that they were intended to evaluate, but which also failed to incorporate the needs and stages of long-term, successful recovery.

In the final article in this series, we will present a concise model of addiction recovery and the elements of which it is comprised which will provide a clear pathway for the reintegration of acudetox and acupuncture as a central and necessary component of effective, mainstream addiction treatment and recovery services.

*See Page 23-24 for references to this article.*

# Asking The Right Questions

*This article is the fourth and final in a series that author and NADA advocate Alex Brumbaugh contributed to NADA's Guidepoints over the course of the 2012-13 publication year (see ad on page 28 of this publication for his book advertisements).*

In the first article in this series, I wrote that my personal interest for several years regarding acupuncture has been to figure out how to get this powerful modality back in the treatment conversation in this country, and to establish acudetox as a central and necessary component of effective, mainstream addiction treatment and recovery services.

In two previous articles in this series, I noted that the burgeoning growth and acceptance of acudetox that began in the 1980s began to decline in 2002 with the failure of the Center for Substance Abuse Treatment to release a TIP (Treatment Improvement Protocol) devoted to acudetox. The primary reason the effort was squelched, according to one observer, came from the National Institute on Drug Abuse (NIDA), the government agency dedicated to research on addictive substances.

This is consistent with the research establishment's intent to force addiction treatment into mainstream medicine by establishing as best practices only those strategies that have been proven effective by "rigorous scientific research," and to not endorse "unscientific" strategies such as "folk medicine," or others that provide alternatives to drug replacement therapies in the treatment of acute symptoms of addiction.

However, as we stated in the last article, the basis of research in addiction treatment is flawed. In spite of the undisputed fact that addiction is a chronic rather than an acute disorder – both the treatment and research establishments have clung to the acute model. The principle reason for this tenacity in letting go of antiquated ways of thinking is that there are no cogent theories or definitions of recovery. This flawed reasoning goes something like this: recovery from cocaine addiction may be defined as the absence of cocaine for as long as we have enough funding to follow–up with the client.

The acute model of addiction treatment, using methods and interventions based on what are thought to be best practices, doesn't work in the long term. The majority of people completing specialized addiction treatment in the United States resume alcohol and/or other drug use in the year following treatment, most within 90 days of discharge (White, 2008a, p. 125).

Clearly, we need to find a broader definition of success in the treatment of addiction. William White (2007, p. 229) writes, "The addiction field's failure to achieve consensus on a definition of 'recovery' from severe and persistent alcohol and other drug problems undermines clinical research, compromises clinical practice, and muddles the field's communications to service constituents, allied service professionals, the public, and policy makers."

At the same time, we need more nuanced research that considers the developmental nature

of recovery and its milestones so that we can assemble a compendium of meaningful and accurate best practices to guide program design.

## *Recovery from cocaine addiction may be defined as the absence of cocaine use for as long as we have enough funding to follow up with the client.*

While some work has been done in developing potentially useful theories and models of recovery (Davidson et al, 2010; Kellogg & Tatarsky, 2011; Moos, 2011; White, 2008), the treatment and research fields still lack a theoretical blueprint that would guide them through the critical transition from an acute to a chronic disease model.

Such a blueprint requires a fairly detailed conceptualization of successful long-term recovery from substance use and addictive disorders. As I have recently proposed in *Praxis of Recovery* (Brumbaugh, 2014), this conceptualization should answer the following questions:

- Does recovery from addiction have a developmental progression that can be a guide to designing effective research studies and treatment programs?
- What are some specific benchmarks, or "recovery learnings," involved in an individual attaining long-term sobriety?
- What environments, service professionals and support services are best suited for a developmental approach to recovery?

Three core concepts arise from these questions upon which we can begin to plan our new blueprint: (1) Recovery occurs in stages; (2) Each stage involves specific developmental needs and tasks, or "recovery learnings," which are needed for success and progress to the next stage; and (3) There are specific benchmarks required for achieving long-term recovery. Recovery can be evaluated at each stage, need, and learning.

Viewed in this way, addiction recovery has similarities to attending school, and each benchmark is, to some degree, discrete.

Passing the fourth grade (mastering the developmental learnings of that grade level) is necessary but not sufficient for success in the fifth grade. Mastery of fourth grade skills, while a prerequisite for fifth grade learnings, does not guarantee success in the fifth grade, much less in the eleventh.

Similarly, successfully managing acute withdrawal does not guarantee or even predict success in managing, for example, anger, a necessary component to recovery. But people who cannot successfully detox in acute withdrawal will never be able to learn how to

manage their anger.

This is the challenge of effective addiction treatment research: to understand these nuances and distinctions and account for them in the designs of treatment programs which form the foundation of future evidence-based practices.

Virtually all long-term studies acknowledge recovery as a stage-dependent process (White, 2008a, pp 59-60). Terence Gorski (1986, pp 84-85) suggested six developmental stages: Pretreatment, Stabilization, Early Recovery, Middle Recovery, Late Recovery, and Maintenance.

In my book, *Praxis of Recovery*, I propose (1) a six-stage hierarchy of recovery needs; (2) sixteen developmental, experiential recovery learnings; and (3) a constellation of interventions and strategies that are most likely to meet the needs of the client and facilitate the recovery learnings. This framework provides a context for assessing the effectiveness of the interventions and strategies, and hence a foundation for establishing evidence-based practices in the context of a chronic disease perspective. Part of the problem of the practice of addiction treatment is that it is guided by research that isn't asking the right questions.

The assumptions made by researchers and treatment planners determine what questions are asked in research studies and designing treatment programs. They ask, for example: Is acupuncture an effective treatment for cocaine addiction? (This question has actually been asked in a number of clinical studies involving thousands of clients).

Compare it with the more relevant research question asked in 2011 by researcher/ psychiatrist Ken O. Carter and others in the Department of Psychiatry, Carolinas Medical Center in their paper "NADA Acupuncture Prospective Trial in Patients with Substance Use Disorders and Seven Common Health Symptoms," published by the Journal of Medical Acupuncture: Is NADA acupuncture effective in reducing the severity of seven common behavioral health symptoms associated with addictive substance use in both acute and chronic aspects: cravings, depression, anxiety, anger, body aches/headaches, concentration, and decreased energy?

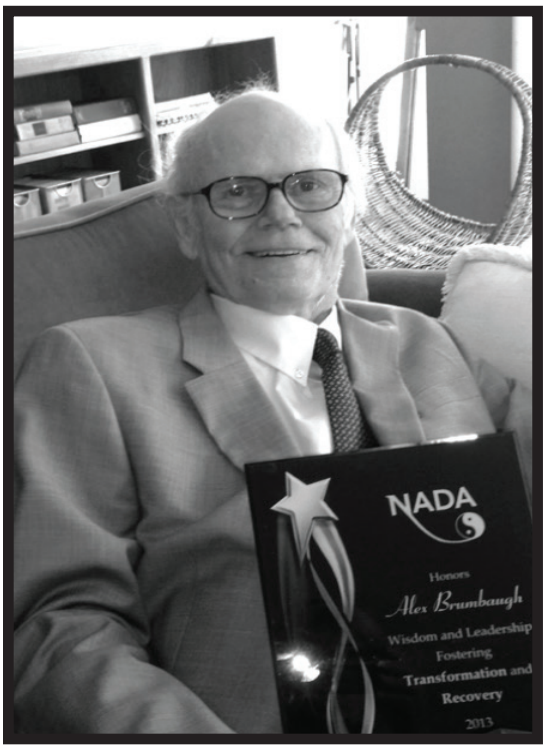
Reducing the severity of any of these seven common symptoms does not guarantee or even predict long–term treatment success. But if all the symptoms, or a good majority of them, are significantly reduced in the first stages of treatment, the client may be better able to transition from the first to the second stage of his or her recovery. A few of the highly important needs of the patient are met, and some important learnings related perhaps to nutrition, exercise, the structure of cravings, and the management of anger, will have been introduced.

Carter has built a theoretically ideal template for evaluating some salient aspects that contribute to long–term success in addiction treatment. Granted that the aspects he chose are acute rather than chronic; when we examine from the broader perspective of chronic illness the full model of stages – needs and learnings – (Brumbaugh, 2014), other salient

## *Part of the problem of the practice of addiction treatment is that it is guided by research that isn't asking the right questions.*

aspects that require evaluation and treatment that extend along the entire course of successful, long-term recovery will be more effectively addressed.

*See Page 25 for references to this article.*




*Alex Brumbaugh*

In this photo, Brumbaugh holds an award he was given by the NADA 2013 Conference Committee, "for wisdom and leadership fostering transformation and recovery." Alex Brumbaugh passed away on the night of May 29, after a year-long battle with lung cancer, diagnosed immediately after last year's conference at Yale. The July 2013 Guidepoints issue contains a tribute to Alex Brumbaugh's visionary work in the fields of addiction treatment and acupuncture.

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## Article Two: Discrediting Acupunture in Addiction Treatment Research

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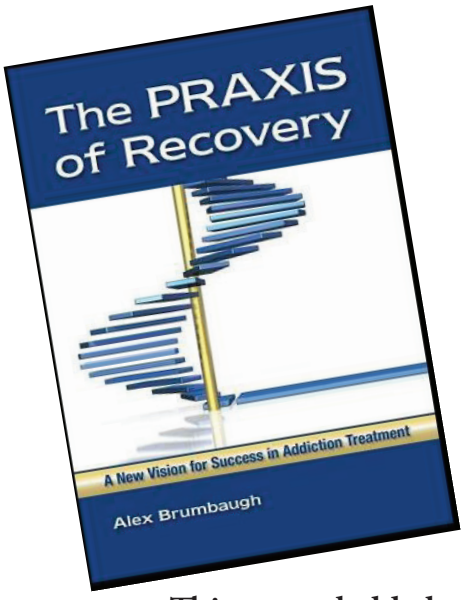


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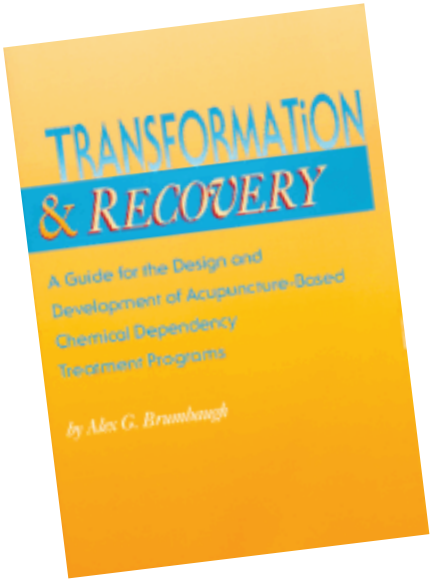


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