WELLNESS ARTICLES

CONTENTS

Healthy Drinking Guidelines

DR. GRAEME CUNNINGHAM, WELLNESS PROGRAM CONSULTANT

Drinking is a personal choice. If you choose to drink alcohol these guidelines can help you decide when, where, why and how.

Low risk drinking helps to promote a culture of moderation.

Low risk drinking supports a healthy lifestyle.

GUIDELINE #1

Reduce your long term health risk by drinking no more than

- 10 drinks a week for women with no more than two drinks a day most days.
- 15 drinks a week for men with no more than three drinks a day most days.

Plan non-drinking days every week to avoid developing a habit.

GUIDELINE #2

Reduce your risk of injury and harm by drinking no more than three drinks for women and four drinks for men on any single occasion.

Plan to drink in a safe environment. Stay within the weekly limits outlined in Guideline 1.

GUIDELINE #3

Do not drink when you are:

- driving a vehicle or using machinery and tools.
- taking medicine or other drugs that interact with alcohol.
- doing any kind of dangerous physical activity.
- living with mental or physical health problems.
- living with alcohol dependence.
- pregnant or planning to be pregnant.
- responsible for the safety of others.
- making important decisions.

GUIDELINE #4

If you are pregnant, planning to become pregnant, or before breast feeding, the safest choice is to drink no alcohol at all.

GUIDELINE #5

If you are a child or youth, you should delay drinking until your late teens. Talk with your parents about drinking. Alcohol can harm the way your brain and body develop.

If you are drinking, plan ahead, follow local alcohol laws and stay within the limits outlined in Guideline 1.

For more information: Check out Canada's Low Risk Alcohol Drinking Guidelines, on the Canadian Centre on Substance Abuse website in the Knowledge Centre at www.ccsa.ca.

What Does 'A Drink' Mean?

- 12 ounce bottle of 5% alcohol beer, cider or cooler
- 5 ounce glass of 12% alcohol wine
- 1.5 ounce serving of 40% distilled spirits.

Tips

- Set limits for yourself and abide by them.
- Drink slowly. Have no more than two drinks in any three hours.
- For every drink of alcohol, have one nonalcoholic drink.
- Eat before and while you are drinking.
- Always consider your age, body weight and health problems that might suggest lower limits.
- While drinking may provide health benefits for certain groups of people, do not start to drink or increase your drinking for health benefits.

Suicide in Health Care Professionals

DR. GRAEME CUNNINGHAM, WELLNESS PROGRAM CONSULTANT

Having treated health professionals for the last 25 years, I have significant experience with suicide by health professionals. It is absolutely devastating not only to the person's family, but also to their patients, colleagues and mentors.

***Editor's Note:**
The Canadian Dental Association and the Canadian Dental Regulatory Authorities Federation jointly sponsored a two-day national conference in Toronto in November 2012 to address drug abuse and dependency and explore the appropriate roles of professional associations and regulators.

Health professionals have high performance expectations in the minds of both the public and themselves. Jobs in these fields are necessarily stressful, which can lead to adverse health effects.

There is no question that the practice of dentistry is an extremely stressful business, but many other occupations are equally demanding and unpredictable.

The higher risk groups are at life's extremes: teenage-young adults and the elderly. Female physicians are three times more likely than their non-physician peers to attempt and complete suicide.

I carried out an extensive literature search and found that there are quite a number of articles on dentists and suicide. I could not find any evidence that dentists are at greater risk of attempting or completing suicide than any other health professional or any other member of the public.

It is interesting to know that, in 1998, the University of Montreal established a prevention program to help future dentists cope with stress before irritability and exhaustion led to depression. The program includes information and training on the issue of stress and burn-out, and the curriculum includes two psychology classes that focus on the theory and practice of the stress that dentists will face.

Throughout my medical career, I have always been impressed at the breadth of training that dental students received both in business management as well as in self-care compared to medical students where the order of education in these areas was zero.

Fortunately there is an increasing dentist and physician wellness movement developing in this country. Your regulatory college here in Ontario is a leader in this area by providing a confidential helpline. It is a privilege and an honour to help dentists and their families.*

Suicidal ideation is not a normal way of thinking. If these thoughts are occurring to you or if they are occurring to any of your family who shared them with you, feel free to call the helpline number and I can discuss privately and confidentially mental health options with you or with your family member.

Did I just drink too much, or do I really have an illness?

DR. GRAEME CUNNINGHAM, WELLNESS PROGRAM CONSULTANT

The vast majority of dentists reading this article will ask “what’s his point?” These are social drinkers who take three or four ounces of alcohol on a social occasion, forget where their glass is and never think about their drinking.

These social healthy drinkers don’t realize that about 10% of us have a disease called alcoholism. When we drink, we develop the phenomenon of craving. This is often a desire for more alcohol at almost any cost and is excessive, because, by definition, we have lost control of our drinking.

This silent minority harbour shame, guilt and frustration. At some level they are aware that their amounts are taken with significant consequences. Drinking is dangerous and inappropriate, but they feel helpless and hopeless to do anything about it.

Similarly, the families feel helpless and hopeless as well. They are hoping that tomorrow dad or mom won’t drink as much or the child won’t use as much drugs as he/she did the previous day.

How do we tell if we are in difficulties with drinking? There are a number of simple questions.

I caution readers. Some of you may find information in this that is disturbing for you and may give you a reason for sober second-thinking.

If you find the answer is ‘yes’ to even 2 or 3 of these questions, you should seriously consider the possibility your alcohol or drug use is a problem. If there are more than a few ‘yes’ answers, you should seek help now.

- Have you ever felt you should cut down or control your drinking or drug use?
- Have you ever felt bad or guilty about your drinking or drug use?
- Did you ever take a morning eye opener to steady your nerves or get rid of a hangover?
- Are alcohol or drugs sometimes more important than other things in your life – your family, your job, your values?

- Do you find yourself lying to your spouse, your kids, your friends, your employer to cover up your drinking or drug use – though you really don't like lying?
- Have you ever switched from one brand of drink to another in the hope that would keep you from getting drunk?
- Have you had a problem connected with drinking or drug use during the past year such as an impaired driving charge, lost work, missed appointments or financial problems?
- Has your substance use caused trouble at home or work? Are those around you annoyed by or concerned about it? Are you annoyed about their concern and do you become defensive?
- Have you been drunk or high more than four times in the past year?
- Do you need to resort to chemical assistance in order to do something such as work, have sex, socialize, or to change how you feel or to banish shyness and boost your confidence?
- Do you crave situations where you can drink such as inviting friends over for a drink or arranging a meeting at a bar?
- Do you panic when your bottle of pills gets low?
- Have you ever felt your life might be better if you didn't drink or take drugs or life as it is just isn't worth living?

We now know that addiction is a brain disorder. It may be inherited or it may occur innocently in an individual. It is important to remind ourselves that the alcoholic/addict has no trouble stopping. They may be arrested, they may pass out or they may have severe withdrawal. The problem for the alcoholic/addict is not stopping, it is starting again.

This means that the addict can't stop starting and this presents a very different picture to someone who might say 'I quit for a month so I can't be an alcoholic.' I remind my patients that social drinkers never have to quit.

If you answered "yes" to several of the above questions I strongly recommend that you speak privately with your family doctor. They can arrange a confidential OHIP-covered assessment by an addiction-trained physician.

Why Call a Stranger?

DR. GRAEME CUNNINGHAM, WELLNESS PROGRAM CONSULTANT

I recall as a practising physician struggling with significant mental health and addiction issues as long ago as the 1980s that my only resource for help from my profession was a toll-free phone number provided by my regulatory body. There was no reassurance of confidentiality. As a sick doctor, I was very reluctant to share my vulnerabilities, wounds and fears with them.

Based on my own personal experience, I felt I should let those of the dental profession who might be considering phoning the wellness number that I am responsible for know a little bit about who I am and what I'm about.

I am a 68 year-old semi-retired Internal Medicine and Addiction Medicine specialist. I practised in Ontario for 40 years, although I grew up in, and did my undergraduate training in, Scotland.

I came from an alcoholic home where my father, a single-handed family doctor, died on skid row in Glasgow in 1975 from the progressive effects of alcoholism. Despite this harrowing experience and difficult upbringing, by 1986 I too developed progressive alcoholism resulting in severe physical and mental damage. At this time, I entered treatment and, after approximately a year, was able to return to practise with dignity as a physician.

After two years of continuing practice as a community cardiologist, my addiction medicine physician explained to me that I probably could not maintain healthy emotional sobriety in such a stressful and demanding medical specialty. As a result, I returned to further training in addiction medicine at the Addiction Research Foundation, completing my American Board in addictions medicine in 1988 and moving to the Homewood Health Centre in 1989. There I established the Homewood Addiction Division, an 87-bed residential treatment program, as well as a large outpatient program. Since that time, the program has treated approximately 5,000 health professionals, including doctors and dentists.

I am very proud of this achievement. Hopefully I have never lost sight of the pain, guilt, shame and utter demoralization of my own addiction experience.

As part of my ongoing wellness, it has always been my own philosophy to try and reach out and help others suffering from similar illnesses. That is why when I was approached by this College's Registrar to staff an anonymous wellness helpline I was only too eager to agree.

Since the establishment of this service, which is completely confidential and at arm's-length from the regulatory body, I have spoken to numerous dentists and their staff and family members regarding a variety of mental health and addiction issues.

I suspect that you folks who have called me have been of more assistance to me than I have been to you, using the old adage that "to keep my sobriety I must give it away."

It is a privilege to be a resource to such a distinguished professional group and I would hope that you continue to feel comfortable to use my services knowing that our relationship is in total confidence and without prejudice.

Children of Chaos

DR. GRAEME CUNNINGHAM, WELLNESS PROGRAM CONSULTANT

Like me, about 76 million Americans or about 43 per cent of the U.S. adult population have been exposed to alcoholism in the family. Almost 1 in 5 adult Americans lived with an alcoholic while growing up. Around 30 per cent of applicants to medical schools have come from homes where one parent was alcoholic.

Thursday was the worst day. This was the half day my physician father took off so the drunkenness and violence at home began earlier than usual.

Studies of family violence frequently document high rates of alcohol and other drug involvement. Compared with nonalcoholic families, alcoholic families demonstrate poor problem solving abilities, both between the parents and within the family as a whole.

These poor communication and problem solving skills may be mechanisms through which a lack of cohesion and increased conflict develop and escalate in alcoholic families.

There are certain characteristics of adults who have grown up in alcoholic homes.

1. Learned helplessness: the adult tends to give up and become helpless and believes they can't affect or change what is happening to them.
2. Depression
3. Anxiety
4. Emotional constriction
5. Distorted reasoning
6. Loss of trust or faith
7. High vigilance
8. High risk behaviours: these include behaviours such as speeding, sexual acting out, spending and other misguided attempts to jump start a numbness in our world.
9. Development of bridge psychological defences: this includes such psychological techniques as denial, splitting, and minimizing.

Despite the fact that many children growing up in alcoholic homes may be high achievers both academically and in sports, a number of elements of behaviour manifest themselves because of learning without adequate role models. These signs can be:

- Constantly guessing at what normal is. It may be that you do not know what "normal" is and you have to try and figure it out from the actions and reactions of others.

- Wondering what you ought to be feeling in different situations. Growing up in an alcoholic home may leave you feeling that you don't know who you are.
- Excessive fear of the unknown.
- Over reliance on watching other people to see how you should be acting. Some children who grow up in alcoholic homes have a tendency to feel that they are different from other people and are uncomfortable in social situations.
- Feeling at a loss when important events occur, like getting married or the birth of children.
- Running to self-improvement books every time change occurs.
- Believing others usually know what they are doing.
- Always depending on others to plan parties, dinners or vacations.
- Feeling like you are pulling the wool over other people's eyes.
- Making big deals about things other people do easily.
- Neglecting things like daily chores and financial records out of ignorance.
- Frequently being surprised to learn that there is a simple way to accomplish things that you usually do in a convoluted way.

While many adult children of alcoholics are high achievers, they continue to live lives of uncertainty and suffer from emotional restriction.

Many adult children of alcoholics lose themselves in their relationship with others, sometimes finding themselves attracted to alcoholics or other compulsive personalities, such as workaholics, who are emotionally unavailable.

They will also form relationships with others who need their help or need to be rescued, to the extent of neglecting their own needs. If they place the focus on the overwhelming needs of someone else, they do not have to look at their own difficulties and shortcomings.

Often, adult children of alcoholics will take on the characteristics of alcoholics, even though they have never picked up a drink – exhibiting denial, poor coping skills, poor problem solving and forming dysfunctional relationships.

This can impact both professional work with patients and also can interfere with relationships in a significant way, especially with marriages and with children.

Help can be obtained through a family physician who is trained to recognize family disharmony and who can recommend a referral to appropriate resources, or you can call me directly to discuss your situation on a confidential basis.

Nitrous Oxide: The Hidden Addiction

DR. GRAEME CUNNINGHAM, WELLNESS PROGRAM CONSULTANT

Dentistry is a stressful profession and those who practise it may be placed at an increased risk of divorce, depression, alcoholism, drug addiction and suicide.[1]

Many factors influence these risks. They include dentistry's inherent stress, the isolation of the practitioner, physical and emotional demands, prescription writing privileges and the availability of drugs.[2]

Isolation is a critical factor as it provides a fertile climate for addictive and self-destructive behaviour. The office often becomes a safe haven for the dentist that drinks and uses other drugs. These factors play a part in what can be seen as dentistry's own specialized addiction, one that involves the abuse of and dependency on nitrous oxide.[3]

The nitrous oxide abusing dental professional is basically confined to his or her dental office due to the constraints of the equipment needed to administer the substance.[4]

Nitrous oxide was first discovered in 1772 by Joseph Priestley. By 1800, nitrous oxide was being used as a purifying gas by practitioners of pneumatic medicine, a practice that used inhalation of specific gases to purify the body of ailments.

One of these practitioners was an English physician named Thomas Beddoes. It was Beddoes' assistant Humphrey Davy, who did extensive writings on the effects of nitrous oxide inhalation. He also held demonstrations of the subjective effects of nitrous oxide by providing it to random subjects at public displays where they would act intoxicated after inhalation of the gas.

The American dentist Horace Wells attended one of these demonstrations in 1844. He observed one subject accidently injure himself while he was under the influence of the gas with the subject appearing totally unaware of the injury or the pain that most surely accompanied it. Dr. Wells recognized the potential of the gas as an anesthetic and proceeded to experiment in its possible use in dentistry and surgery.

As a result, nitrous oxide has become one of the most widely used inhalation anesthetic gases in medicine and dentistry and has become the almost exclusive inhalation analgesic used for the reduction of anxiety.[5]

At lower to moderate concentrations, nitrous oxide produces analgesic and emotional effects similar to the narcotic analgesics. Recent studies indicate that nitrous oxide may exhibit its analgesic effects by influence in the body's own endogenous opioid system or directly at the opioid receptor sites of neural synapses.[3] By acting as an opioid, the inhalation of nitrous oxide produces similar euphoric effects that drive the addictive properties of other narcotic analgesics such as morphine and hydrocodone.

Researchers have called for the reclassification of nitrous oxide as an opioid and to have it regulated as such.

Chronic nitrous oxide abuse exhibits certain physical health risks. Most notable is a peripheral neuropathy that manifests itself as a loss of sensory perception, initially beginning in the hands and feet of the abuser. This neuropathy has been shown to be the result of demyelination as a result of a disruption of vitamin B12 metabolism.

The clinical presentation of the chronic abuser of nitrous oxide is the same as the clinical presentation of an individual afflicted with pernicious anemia (vitamin B12 deficiency). This anemia is a severe medical condition caused by the absence of intrinsic factor, the protein necessary for the absorption of vitamin B12 (cobalamin) by the intestine.

Along with the neural toxic effects already mentioned, nitrous oxide abuse can also result in severe, megaloblastic anemia.

In summary, chronic nitrous oxide abuse can produce abnormalities in bone marrow activity as a result of the interference with enzymes containing cobalamin.

Many times nitrous oxide abuse/dependence is a silent addiction within the dental profession. Individuals afflicted with this addictive disease can go undetected until significant physical and personal damage has occurred.

An increase in the number of nitrous oxide cylinders used in the office in a month, an increase in the amount of time spent at the dental office alone after hours and on weekends, loss of coordination while handling dental instruments or a stumbling gait may all be signs that someone is abusing this anesthetic agent.

Dentists, dentist's family members and dental office staff are encouraged to contact me on the confidential hotline if you have any concerns regarding nitrous oxide abuse or dependency and any other substance use disorders. This service emphasizes individual advice, support and direction without any requirement for College involvement.

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THE PSYCHOLOGY OF THE 12 STEPS

How the 12 Step Program Allows Addicts to Grow up

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Development of Alcoholics Anonymous

The development of AA connects back to Swiss psychiatrist Carl J. Jung who, in the later 1920s, stated that his alcoholic patient Roland H. would only recover from his severe alcoholism through a conversion experience.[1] Roland returned to New York, joined a fundamental religious group and had such an experience.

Roland conveyed this information to another member of his group, Ebby T. In November 1934, Ebby visited his friend Bill W., a failed stockbroker with advanced alcoholism, who was immediately impressed with Ebby's sobriety. Bill also managed to achieve sobriety after having a spiritual experience that arose from his despair and depression.

Following his discharge from hospital, Bill attempted to help other alcoholics. After many failures, he shared his frustration with his physician, Dr. Silkworth, who responded: "...for God's sake, stop preaching. Tell them about the obsession and the physical sensitivity they are developing – say it's lethal as cancer – a drunk must be led not pushed." In May 1935, Bill met Dr. Bob Smith, a surgeon in Akron, Ohio and the two became co-founders of Alcoholics Anonymous.[2]

It took several years to develop the Twelve Steps and the Alcoholics Anonymous guide book. Groups of alcoholics who supported each other and used the 12-step program gradually sprung up throughout North America.

During this evolution, AA grew apart from its fundamental religious roots and eventually disconnected from any religious association. The program's spiritual nature is very personal and accepting of any experience so that atheists and agnostics can actively participate.

Over the next 15 to 20 years, the business aspects of AA developed, including the Twelve Traditions, Twelve Concepts and Six Warranties. These are sometimes referred to as the Constitution of AA.

This process resulted in a program that is still the most effective method for maintaining sobriety. Harvard Medical School psychiatric professor George F. Vaillant, in a prospective 30-year follow-up, found that the number of AA visits made by people explained 28 per cent of the clinical outcomes of sobriety. Of interest in this study, medical or psychiatric treatment did not explain any of the clinical outcomes for recovering alcoholics.[3]

The development of the Minnesota Model of Treatment, which combined professional treatment with AA, resulted in an improvement in treatment effectiveness. A recent prospective study of employed alcoholics found that treatment plus AA was more effective than AA alone in helping employed alcohol abusers attain and continue abstinence. This study confirms the value of combining professional treatment with AA.[4]

With roots in medicine, psychoanalysis and religion, AA is compatible with psychiatric treatment. The difference is that AA is not under professional control; it is protected by a set of traditions that have successfully maintained the organization and its program for over 60 years.

We need to understand that AA does not:

- solicit members
- charge user fees
- control or follow-up with members
- provide housing, meals or transportation
- provide medical, psychiatric or nursing care
- join councils or social agencies
- accept money from non-members

How AA Works

Khantzian & Mack provide strong theoretical backing for considering AA as specific treatment. They describe AA as a “sophisticated psychosocial form of treatment that addresses human psychological vulnerabilities that alcoholics and others share related to problems of self-regulation.”[5]

The therapeutic aspects of AA they emphasize are:

- the installation of hope through contact with others;
- the encouragement of openness and self-disclosure;
- repeated emphasis on shared experiences;
- a focus on abstinence;
- an insistence that one cannot get better on one’s own;
- a spiritual dimension that helps move a person from self-centredness towards a capacity for humility and altruism.

The aspects all contribute to a positive shift in ego defense mechanisms and to a character change.

Elements of AA Recovery Program

The AA Recovery Program has three main elements:

1. MEETINGS

There are a variety of meetings and, if an individual does not like one type of meeting, they are encouraged to try others until they find a group they are comfortable with. Newcomers are considered the most important people at AA meetings.

Patient resistance to attending 12-step meetings is usually highest when a diagnosis and referral is first made. A useful metaphor for AA meetings is to view them as a medication. To be effective, they need to be taken daily in the first three months of sobriety. Most treatment programs now recommend 90 meetings in 90 days in recognition of the high risk of relapse in the first three months and the need for an intensive experience to break through the defenses of denial, projection and isolation.

2. THE FELLOWSHIP

Meetings introduce alcoholics to other like folks in various stages of recovery. An important aspect of recovery is obtaining a sponsor who has experience with the program as well as with living sober.

This individual can act as a mentor and guide on the journey of recovery. Studies have shown that having a sponsor is associated with a reduced risk of relapse and that acting as a sponsor also improves the program's outcome.

3. STEP WORK

The Twelve Steps provide the core of the program. Each step presents a specific problem and can be assisted by a family doctor or specialist physician. In return, as the step is worked, it can facilitate psychotherapy.

The 12 Steps of AA

1. We admitted we were powerless over our chemical – that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We're entirely ready to have God remove all these defects of character.

7. Humbly asked him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to addicted people, and to practise these principles in all our affairs.

STEP 1 means becoming comfortable with a new identity as a recovering alcoholic and marks the beginning of sobriety.

STEP 2 requires a belief that someone greater than or different from him or herself can be of help. This is left up to the individual and requires an acknowledgement that "I cannot deal with this problem myself and need help." This common human experience can help reduce resistance stemming from an unrealistic self-image that requires a person to solve every problem alone.

STEP 3 is a difficult step and requires a conscious surrender of one's will in life to the "power" one has begun to appreciate in the previous step. This step often manifests a struggle between prior religious experience and the entity of spirituality. The alcoholic is encouraged to trust the individuals in the home group and at meetings to help him or her until they begin to experience some healthy inner control.

STEP 4 is also difficult but for different reasons. Working this step usually triggers guilt, shame and grief; it should be done with a sponsor. Support by physicians, without medication, can also be very helpful. The benefits of self-knowledge and self-awareness that come from working this step are extremely valuable.

From my own experience, recovering alcoholics who have worked Step 4 are more comfortable with and responsive to psychotherapy and it significantly helps in the maturation of ego.

STEP 5 is also a form of preparation for psychotherapy. Individuals are anxious and sometimes anticipate a negative response from the person they share with. In many cases, sharing with another human being is usually a relief. Individuals listening to these admissions never reject or punish. Although this step is therapeutic, it is not true psychotherapy.

STEP 6 is derived from Step 4. Behaviours directly associated with the use of alcohol will usually stop with abstinence, but other character traits will remain. This step demonstrates a willingness to

develop behavioural change. Self-awareness without feedback from one's social support system is much more difficult than self-awareness of ego dystonic behaviour. Psychodynamic psychotherapy and psychoanalysis, both individual and group, interact in a positive way with this step.

STEP 7 is fascinating. It seems to take place internally but it is externally observed. As my wife once put it "it's in their eyes."

The humility required for this step reawakens the experience of Step 1. The difference is that it is easier to stop alcohol abuse than to change your personal character behaviours. Change does occur in selfish, blaming or grandiose behaviours. It serves as a great source of hope for others. Alcoholics continue to attend AA meetings years after abstinence has begun not only because they are worried about returning to drinking, but also because they find that working on their own pathological issues is a challenging, positive and rewarding experience.

STEP 8 develops from Step 4 and puts the alcoholic in a state of preparation for relational repair. This step may also help the individual develop the capacity for empathy and it is basic to developing relational skills that can assist the gains made in individual therapy.

STEP 9 puts relational skill into practice and, although usually accompanied by anxiety, it is an extremely positive experience. The recovering person can learn the importance of forgiving oneself, even though working this step does not necessarily result in being forgiven by others.

STEPS 10–12 are said to be maintenance steps. They work by being a continuous stimulus to both personal relationship goals and character change. Spiritual health is improved and working these steps also expresses gratitude.

Working at AA or other recovery programs is usually accompanied by periods of emotional distress. The best results usually come when these symptoms are looked upon from a developmental rather than a pathological point of view. AA members view these symptoms as a motivation for change. They are likely to resent and resist efforts to medicate themselves and many recovering alcoholics now believe that it is important for them to experience and work through these negative feelings in order to change for the better.

The Goal of Recovery

Two characteristics of recovering from alcoholism and other addictions are:

1. The ability to manage the stress of living without the support of dependent drugs. This ability is unusual in society where the use of alcohol and prescription medications as stress management is widely accepted.

2. The ability to be around dependence-producing drugs without experiencing craving or engaging in drug-seeking behaviour. This explains why drug dependent health care professionals, given a recovery process has occurred, are able to return to their practice and its associated availability of drugs.

The other aspect of recovery that appears to result from 12-step work is a shift from the immature ego defense mechanisms of denial, projection, minimizing, grandiosity and acting out to more mature ego defense mechanisms of altruism, humour, suppression, anticipation and sublimation.

The following characteristics occur in individuals working a recovery program over a period of time:

- an honest openness and willingness to learn;
- personal humility with a tolerant acceptance of others;
- compassion and altruistic caring (willing to help others without compensation);
- gratitude for the experience that we have had, for relationships and for the program.

In summary, recovering alcoholics become the kind of people most of us would like to be.

Conclusion

In treating the disease of addiction, AA and other 12-step programs provide powerful psychosocial therapies that can enhance psychotherapeutic treatment provided by other care givers including physicians and psychiatrists. When the physician motivates and supports a patient to actively work a 12-step program, a complementary stimulus to growth and development will be added to the psychotherapeutic effect of treatment.

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"Am I my Colleague's Keeper?"

Should Dentists Care About Other Dentists' Health?

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This disease of addiction shows no favourites. Dentists as well as other health professionals are susceptible to this disease just as they are to other diseases that plague mankind.

Evidence gathered from well-designed studies over the past 30 years has shown unequivocally that addiction is a disease, one that comes about from an inheritable predisposition and is expressed through changes in the biochemistry of the brain.

Addicted dentists who are reluctant to seek help, who cast a blind eye to their problems, are hurting themselves, their families and their patients, but also the dental profession as a whole. There is help available.

Since the mid-90s, there has been an increasing awareness of the need for support of the health and well-being of health professionals. This began with the well known Physician Health Program that is now established in every state in the United States and every province in Canada. The American Dental Association is part of this movement towards supporting dentists. Now Ontario is leading the way in Canada to develop a confidential and collegial supportive service for dentists and their families who have addiction issues.

Who's at risk?

From the perspective of substance use disorder, dentists are no more at risk than the general public. However, they do have a number of risk factors by the very fact that they are dentists.

There is a significant genetic risk. Many dental students come from a home where one or more of parents have been alcohol dependent. The personality characteristics of obsessive compulsive traits, perfectionism, the ability to work extremely hard and not looking after one's own needs: these are characteristics of dental students at risk of substance abuse.

In addition, many dentists practise in solo practice and use mood altering medications both for anesthesia as well as analgesia.

It is possible that self-administration of these chemicals is a risk and at times does occur; for example, the misuse of nitrous oxide.

It has been the experience of the Homewood Health Centre Health Professional Treatment Program that most dentists entering the residential program use alcohol as their drug of choice, but many have also had experience with nitrous oxide, cocaine, and the opiate class analgesics.

How does it impact a dentist's life?

Addiction has been described like a target with the addicted dentist in the centre and concentric circles representing the various areas of his or her life that have been affected one by one by the disease process:

- Initially family life: Family fights, separation and divorce, extramarital affairs and absences occur.
- Employment status: This is reflected later in job changes, intervals between positions, and inappropriate references from jobs for which the dentist is apparently over trained.
- The dentist's health: Often a complicated or vague medical history develops, deterioration of physical appearance occurs, withdrawal and intoxication signs are noted and accidents occur.

Professional duties are affected in terms of missed appointments, angry outbursts, sloppy surgical technique and poor dental judgment.

Office personnel are often the first to notice the changes in the dentist's conduct; mood swings and slurred speech over the telephone are noted. Day-to-day professional conduct is impacted. By the time the disease manifests itself in the office setting, the dentist is very ill.

What questions should be asked?

Many of us use alcohol and licit drugs in a safe and healthy fashion under the supervision of our own physician or healthy family members. However, a number of us cross the line into dangerous substance use. This is sometimes related to stress at work or just simply the habit of drinking alcohol nightly for relaxation purposes.

In the American Dental Association National Dentist Wellbeing Survey, dentists were asked four questions:

1. Have you ever felt that you should cut down on your drinking or drugging?
2. Have people annoyed you by criticizing your drinking or drugging?
3. Have you ever felt bad or guilty about your drugging or drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

If, as one answers these questions, the answer is positive to any two questions, there is an 80% correlation with alcohol dependency. If one answers positive to three or more questions, there is virtually a 100% correlation with alcohol dependency.

This simple screening set of questions used by family physicians and emergency room doctors very quickly separates folks who are heavy social drinkers from people who have moved into problematic alcohol or drug use.

Readers of this article can identify themselves within these questions. It is recommended that if you fall into the population who are answering positive to two or more questions, it is advisable that further discussion take place with your family physician.

Principals of intervention

The basic principals of success in intervention consist of the following:

- It should be carried out by more than one colleague, particularly those in positions of authority.
- It should occur when the dentist is sober and soon after an incident precipitated by the problem.
- The location should be quiet and non-threatening.
- Documentation of specific incidents of impaired behaviour should be used if available.
- Colleagues should have a non-judgmental attitude – the dentist has an illness.
- Anticipate possible reactions such as denial, anger and threats including legal threats.

The goal is for the dentist to agree voluntarily to an assessment by an independent specialist rather than to accept a stigmatizing diagnosis and mandatory treatment.

What is treatment?

Treatment of any addiction must begin with abstinence. Abstinence is the key that allows one to enter the room known as recovery. Abstinence is not a goal, it is a state which sometimes needs to be reached through management withdrawal mechanisms or sometimes can simply be reached by quitting drugs or alcohol oneself.

Basically treatment is simple. It teaches the addicted dentist how to be sober and how to maintain sobriety despite the normal buffeting of daily life events.

The core of being addicted is to be isolated; therefore the treatment is to help the dentist bring healthy people back into his or her life who can support the journey in sobriety.

Once diagnosed and treated, the prognosis for dentists is excellent. A number of studies have demonstrated an excellent prognosis for addicted dentists who have completed treatment and who have continued on a long-term monitoring program. However, duration of the follow-up care is of key importance.

The monitoring program may simply be attendance at Alcoholic Anonymous meetings and a health professional support group, or it may be more intense involving urine monitoring as well as aftercare contracts.

In this age of increased accountability for health professionals, a significant international wellness movement has developed and the Royal College of Dental Surgeons and the Ontario Dental Association have to be congratulated in leading this initiative in the dental profession in Canada.

Afterall the goal is to move dentists from the place of shame of a stigmatizing illness to the dignity of recovery.