Foreword

David Sinclair, PhD

ON THE DAY that the first draft of this book was due at the publisher in Texas, Dr. Roy Eskapa was in the foothills of the Himalayas, introducing the method for treating alcoholism to CORD, a non-governmental organization working in rural northern India.

I was in Finland and had been checking scientific points in the manuscript. Naturally it had taken me twice as long as anticipated, and Roy got my comments only shortly before the deadline. The delay created a problem. He could, with some difficulty, get my simple e-mail messages through his mobile phone even in the small village near Dharamsala. A broadband Internet connection would be needed, however, to transmit the entire manuscript to the publisher, and there was none.

The only nearby access to the Internet was further up the mountain, in McLeod Ganj, the village where the Dalai Lama lives with his followers. I could not even find the road up to McLeod Ganj

on Google Earth, but apparently it does exist. It's just small—winding, full of potholes, Tibetan monks, goats, and cows. And motorbikes. So Roy found a fellow in Dharamsala who would rent him an old Royal Enfield motorbike.

With the book stored on a USB memory stick in his pocket, Roy got on the Enfield and started up the mountain. Past the goats and cows. But as he neared McLeod Ganj, the motor sputtered and died.

The bike could go no further up the road, but it could go downhill. So Roy turned around and coasted back down the slope, past where he had started in Dharamsala, until he finally found a mechanic.

In five seconds the spark plug was fixed, and Roy was on his way up the road again.

Halfway to McLeod Ganj, the Enfield stopped again. This time the chain had come off. Roy coasted back down the hill one more time. The repair this time took an hour, but in due course Roy was back on the road and up the mountain, past Dharamsala and the fellow who had rented him the bike to begin with. And this time—since this was his third try—Roy succeeded in reaching his destination, the Green Cyber Café in McLeod Ganj.

Transmitting the whole manuscript was still difficult: the computers at the Internet café were all occupied, but the owner allowed Roy to use his own terminal. The connection was slow and spotty and just as the manuscript was almost completely sent, there was a power failure. Roy tried again and there was a second power failure. On the third try (of course!), the entire book flew from the Internet café at the roof of the world, went halfway around the world in a heartbeat, and arrived safely at BenBella Books in Dallas.

Dr. Eskapa has faced many obstacles in writing this book, though few of them involving broken motorbikes, and his tenacity, energy, and dedication (not only with the book, but also in promoting its new and effective treatment for alcoholism) are the reason you're holding *The Cure for Alcoholism: Drink Your Way Sober Without Willpower, Abstinence, or Discomfort* in your hands today.

I have been most fortunate in that I've been involved in the development of this new treatment method since the beginning. It is very rare that a scientist gets to see his work go all the way from theory to laboratory experimentation to clinical trial, and then on to a safe and approved application. But there is one more step I hope to see, and it is this step that I hope this book will help accomplish. If this method for treating alcoholism is going to fulfill its potential, doctors and patients must know about it and understand it.

The Cure for Alcoholism should also reduce the problem that currently only a small fraction of those people who need help ever seek treatment. This is understandable with the traditional treatment method, which I call the "**D** Method." Consider the steps involved in most current treatments and imagine if you would want to sign up:

Detect. Before you are allowed to start treatment, you have to admit that you are an alcoholic, with all the stigma that unfortunately (and incorrectly) is associated with that label.

Delay. Once you have finally agreed to say, "I am an alcoholic," and developed enough courage and motivation to go into treatment, you may be told that the earliest opening in the program is three months or more away. This is more of a problem in some countries than in others, but where it does exist, it takes the heart out of seeking help.

Detox. You start with the horrible experience of alcohol withdrawal. If no medications are used, detoxification is painful and disturbing; it may even be fatal. It also destroys brain cells. If medications are used, they're usually addictive drugs: benzodiazepines such as diazepam (Valium) or chlordiazepoxide (Librium) or barbiturates such as phenobarbital (Luminal) and pentobarbital (Nembutal); these drugs will help you through the alcohol withdrawal, but you may end up—as many do—with two addictions rather than one.

Detain. Next you are put away for weeks in a place—rehab—where it is supposed to be impossible to drink. You have to put your life on hold to do so, forcing you to choose whether to lie to friends and coworkers or else tell them you're an alcoholic and

risk their reactions. If you're lucky, your job will be waiting for you when you return. But only if you're lucky.

Don't **D**rink. All this time, the main thing you want to do is to drink. Nothing has weakened the craving and now, after weeks of alcohol deprivation, it is even greater. Yet, the main thing everyone tells you is, "Don't Drink!"

Denigrate. Some treatment facilities will attempt to break your spirit and resistance, for example, by insulting you, waking you up at odd hours, making you perform demeaning jobs, and forcing you to confess all your past sins in public.

Disulfiram. You are in treatment because you cannot resist drinking. Now, without doing anything to improve your ability to resist drinking or to reduce your craving, the facility's doctors may put you on a prescription of disulfiram (Antabuse®), where if you do what every fiber of your body insists you must do—drink alcohol—you will suffer agonizing torture and may even die. You must face this ordeal every day for the rest of your life. The disulfiram will do nothing to abate your craving, and if you ever stop taking the disulfiram, your craving will probably be greater than it was before you started taking it.*

Dollars. The treatment, especially because of the inpatient detoxification and detention steps, is very expensive. You have to be able to afford this even though, during your detention, you won't be collecting your regular paycheck and may even lose your job.

And finally: **D**o it all over again. The odds are very high that within a year or two you will be back where you started, deciding whether to go through the treatment again, and then again. . . .

The new method detailed by *The Cure for Alcoholism* changes all of the **D** steps. There's no **D**etection. Our method is for anyone who wants to control their drinking. No **D**elay. The treatment is

* Soon after I first wrote this, an old friend, Pat, asked me about Antabuse capsules because the alcoholic husband of a friend of hers had been given one. I told her that I thought its use was similar to the treatment of the Abu Ghraib prisoner told he must keep his arms raised or else suffer agonizing torture and even die. I met Pat again recently and she said, "You remember the alcoholic who was given the Antabuse capsule and told that if he drank, he would die? Well, I just heard that he drank, and he died." She went on to explain that he had abstained for about a month, but eventually could take it no longer and started sipping alcohol. Personal problems arose. Finally, he bought and drank a large amount of alcohol. And died. I suspect his action was similar to that of a prisoner who finally chooses death over further torture.

completely outpatient and can start immediately. No **D**etox. You drink as you normally do, but because of this method, your craving slowly decreases, so your drinking also decreases gradually and safely. No **D**etention. No **D**isulfiram. No addictive or dangerous drugs. No **D**enigration. Your dignity is emphasized. Costs are reduced. And there is no revolving **D**oor: the method works the first time around and instead of relapsing, patients get progressively better the longer they have been undergoing treatment.

We should not blame doctors and clinicians for this **D** Method. Until now, it was the best they had to offer.

Let me give an example. I had just given a lecture to the staff of a hospital in Massachusetts explaining pharmacological extinction, the key concept in this new method, and how to use it to help their patients. The head physician, Dr. Michael Pearlman, liked our results and was excited about using the extinction method. On the way out, he introduced me to one of the patients, Kathy, and told her I had developed a new medicine for treating alcoholism.

Kathy looked at me suspiciously. "Is that one of those medicines where you can't drink anything?"

I replied that ours was almost the opposite. You had to drink for our medicine to work. She thought that was an interesting idea.

I described how drinking was learned. She agreed: she'd been there and done that.

Then I explained how learned behaviors could be removed by extinction. She had heard about Pavlov and how he used extinction with his dogs to eliminate their conditioned responses.

The new treatment made sense to her. "I think I might like to try that . . . but I don't want my usual doctor here giving it to me. He steps on me for my being a mother and all."

I assured her that degrading patients was not part of the procedure. "Indeed, one of the rules I insist upon is that patients must be treated with dignity."

She looked up at me with a surprised glow. The idea of being treated with dignity had not occurred to her in a long time.

More important, however, was what Dr. Pearlman told her: "You

see, Kathy, before we did not have naltrexone and extinction. So we used any hammer we had to try to make you stop drinking, including telling you that you are a bad mother if you drink. But now we have a better way."

The goal of this book, at least initially, was to inform folks in America about this new method. Developed countries, like the United States and Finland, would certainly benefit from it. For most patients, it does—as the book's title says—provide the cure for alcoholism. It is safer, cheaper, more humane, and more effective than other treatments.

Where the method has the greatest potential benefit, however, is in developing countries.

The situation is similar to that with mobile phones. They provide benefits in countries like America and Finland where there is already an existing infrastructure of landlines, although to some extent landlines are in competition with mobile phones and can hinder their development. Mobile phones really shine, however, in places where there is no infrastructure, as in much of Africa. Mobile phones in these places provide the capacity for "leapfrog technology," connecting people to one another and to the world without first having to spend a fortune stringing cables across the land. They allow developing countries to skip that intermediary step entirely.

The same is true for our treatment. It does not require prior detoxification or detention. The first clinical trial in the world treating alcoholics without prior detoxification was the one we conducted here in Finland: patients who were drinking yesterday are simply told to take naltrexone or nalmefene before drinking today.

I once gave a presentation at an alcoholism treatment hospital in Virginia. The staff understood how pharmacological extinction worked and accepted the results I showed them, but mentioned one problem: "What are we supposed to do for a living?" The hospital received a certain amount of money for each alcoholic it detoxified. Where would the money come from with a treatment that skipped inpatient detoxification?

This may have been an obstacle to the spread of the treatment

in America and other developed countries, but it is a major advantage in developing countries. They have not invested millions building facilities for detoxifying and detaining alcoholics. They do not have large numbers of people already trained to work in such facilities. Our method, therefore, could provide developing countries with another form of "leapfrog technology," allowing them to help their people with alcohol problems without first having to spend a fortune building a treatment infrastructure.

Using the new method where traditional treatments have not been established sounds good on paper, but would it work in practice? Dr. Eskapa has shown it probably will. He introduced the treatment to the clinicians working with CORD in northern India. CORD's national director, Dr. Kshama Metre, recently sent me the results from their first twenty-eight patients. They had a 75 percent success rate. This is virtually the same as the success rate we found in our clinics in Finland and close to the rate reported by clinics using the method in Florida. Of course, the sample from India is still small, but there is no reason to suspect the method will work differently in different countries. Unlike many alcoholism treatments, extinction with naltrexone or nalmefene should be relatively independent of cultural factors.

Recently, I was describing the science behind the new method to a young visiting scientist in our lab in Helsinki. It was gratifying to find that he accepted without hesitation each of the major discoveries and conclusions leading to pharmacological extinction, but I was not really surprised. Today, these points are generally accepted by most of the leaders in the field. After my talks, I am often told that the top clinicians in alcoholism treatment knew all of this all along. The consensus for decades has been that alcoholism is a learned behavioral disorder and that the endorphin or opioid system at least played a role in the reinforcement of drinking. Extinction has been known for over a century to be the mechanism for removing learned behaviors. The obvious conclusion to anyone putting these points together is that naltrexone and nalmefene could be used to extinguish alcohol drinking. I am not sure why others, with the notable exception of Abram Wikler in the field of

heroin addiction, did not previously speak out more about the use of extinction in de-addiction treatment, but it is more important that most of the alcoholism experts agree with the conclusions today. Such approval within the field may mean that the time has come for this method's general acceptance among doctors and patients. *The Cure for Alcoholism* may well play a critical role in establishing this acceptance. And hopefully, with this acceptance will come a more enlightened era—of truly *curing* addictions.

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