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Reflections of an Addiction Psychiatrist: An Interview with Dr. Sheila Blume

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Introduction

Dr. Sheila Blume created an enduring legacy within the modern treatment of addiction. After her medical training at Harvard in the mid-1950s and her psychiatric residency

at Central Islip Psychiatric Center in New York, Dr. Blume directed the Charles K. Post Alcoholism Rehabilitation Unit at Central Islip and later served as the Director of the New York State Division of Alcoholism and Alcohol Abuse, the Medical Director for the National Council on Alcoholism, and the Medical Director of Alcoholism, Chemical Dependency, and Compulsive Gambling Programs at South Oaks Hospital. She served in numerous leadership positions within the field over the course of her career, including the President of the Board of Directors of the American Society of Addiction Medicine, the Board Of Directors of the National Council on Alcoholism and Drug Dependence, the Board of Trustees of

the JACS Foundation (Jewish Alcoholics, Chemically Dependent Persons, and Significant Others), and the Board of Directors of the National Council on Problem Gambling. I recently (March, 2015) had the opportunity to interview Dr. Blume about her career and the evolution of the field to which she has dedicated so much of her life. Please join us in this engaging conversation.

Entry into the Field

Bill White: Dr. Blume, perhaps we could begin with the story of how you came to specialize in addiction psychiatry.

Dr. Sheila Blume: There was no such specialty when I entered the field back in the '60s. I started out in pediatrics in my internship, and then my husband and I went around the world for three years. We started with Fulbright [Fullbright Scholars Program] grants in Tokyo and then went to England for a couple of years. We also had two children during that time. While I was having our children and living in rural England, I didn't work as a physician, but I did a lot of reading on psychiatry because I thought that being a

good pediatrician required understanding more about human development, parenting and relationships than was ever taught in pediatric training at that time. When we returned to the United States in 1962 and settled down on Long Island, I decided to take a psychiatric residency at a local psychiatric hospital. It took about one day there to turn me into an addiction psychiatrist.

My first day on the job, I was assigned to a women's admission unit within what was this huge old state hospital with ten thousand patients. I found, to my horror, that although I started my training on September the first, I'd been assigned patients since July the first, and there were still patients in the hospital assigned to me over all this period being cared for by the other psychiatrists in training. So I spent that first day, not looking around the hospital as I hoped to do, but interviewing a long list of women who had been waiting for months to meet Dr. Blume, their doctor. It was really quite an experience because I had no knowledge of psychiatry and no training up until that moment. And I found myself responsible for all these people.

I went home that night and asked myself how I could best proceed. What I decided to do was to pick from my assigned list of patients the woman I felt was the sickest and the patient I thought was the least sick and spend whatever time I could with them to learn about them in some depth. As for the other patients, I would provide whatever standard treatment my colleagues were providing. The woman I thought was most sick was acutely psychotic and talking in gibberish--what we then called "word salad." The woman I thought was least sick was an alcoholic school teacher who was quite rational and well-motivated and struck me as someone who would be easy to work with. That began my education. The psychotic woman got well on Thorazine and in a couple of weeks was out of the hospital. We struck up a wonderful relationship that lasted for several years. She would come back and see me and later write me. So, you would think with that early success that I would have specialized in the treatment of

severe mental illness, but I didn't. It was the alcoholic woman who most engaged me. She had no idea how to stop drinking and, of course, I had no idea how to help her do that. But we decided to do our best and work on it together. I looked in the textbooks, of course, and there was nothing written on how to treat an alcoholic and it was clear that to me that psychoanalysis was not the answer. I was drawn to fill this void in psychiatric treatment.

Bill White: How would you characterize the attitudes toward alcoholism and addiction that you experienced at Harvard Medical School in the '50s and then also and in your psychiatric residency in the early '60s.

Dr. Sheila Blume: There were two concurrent points of view: one was that it wasn't our business, that psychiatry might be interested in why a person would use alcohol to excess or drugs but it was the psychological process and not this aberrant behavior that was our business. That's a strange way to look at it, don't you think, but that's the way it was. And the other was really looking down upon it: this is not worth doing. There are much more interesting things to work on.

Bill White: Did that affect the response of your medical and psychiatric peers to your decision to specialize in addiction?

Dr. Sheila Blume: Well, when I was struggling with this lady--who later fully recovered--I went to my supervisor for help. It was the guy who ran our service who set me on my path. When I asked him for help with this patient, he answered me with the two words, "Why bother?" That was the attitude of much of psychiatry towards alcoholism at that time. Can you imagine how many patients went for help and got that kind of a reception? I was too polite and perhaps too junior to tell my supervisor how angry his words made me, but I vowed that I was not going to leave this thing alone. The patient taught me about alcoholism. I got together a group of alcoholic women on this service because nobody else was interested in them. I think it was the first group of women in a therapy group in the state,

certainly the first in the state hospital system. And these women were my teachers. They were all local people and so after they left I got together some outpatient aftercare services to offer continued support to them. That was the nice thing about the state system: there wasn't anyone watching you too much. As long as you behaved yourself and didn't cause any trouble, you had a lot of latitude to explore new ways to be helpful.

Bill White: In your early career, you were a woman in a male-dominated medical field and an emerging addictions field. What was that experience like for you?

Dr. Sheila Blume: I wouldn't say the emerging addiction field was male-dominated. From my point of view, people were so hungry to communicate with people who were doing what we were doing and to compare notes and support one another that it didn't much matter to anybody whether we were male or female. Our early professional gatherings were a combination of men and women and I didn't see any vying on the basis of gender. So that wasn't a problem. In the state system where I was, there were also lots of women and many foreign-educated psychiatrists. They were wonderful because to fill these roles you had to be ambitious and very smart. In the state hospital system, gender didn't seem very important.

I do recall one time that gender was an issue. I got into the addiction field through my interest in alcoholic women, but the state decided to start an experimental alcoholism treatment unit for men at our hospital because we were the only hospital that had AA meetings regularly. We had AA regularly because one of the people on our community advisory board—every state hospital had to have one—was a recovered alcoholic and insisted that this be done. He came from a wealthy and prominent family and so it was done. The AA meetings were on the men's unit, but I had forced the issue for them to allow my women to go up to the AA meetings. So, that was good because the women had to fight their way in, and that made going to meetings a more valuable experience.

The new (all male) alcoholism unit was just beginning to get going when the senior psychiatrist in charge went off on a leave of absence and they needed someone to take it over. We had over a hundred psychiatrists on our staff for our ten thousand patients and not a one of them would agree to take it over. Then the director remembered that there was this trainee who kind of had a feeling for "these people," so they called me in and asked me if I would take over this unit for them. And that's when I had my only sex-related negative experience. There were two residents assigned to help the guy who had just left. One of them was from a Central American country and they were both older than I. (I was always the youngest person around.) One of these residents walked into the building and said he wasn't going to work for a woman, and walked out again. That was the only time ever I can recall gender being an issue, and this turned out to be a good deal for me because I had a friend named John Pitrelli in my own resident class (we were both second-year residents), and I asked if I could have him and they said, "Sure." He was delighted to come and so he was a great help to me in getting this program going. It was so successful that alcoholism units were set up in state hospitals all around the state. I think there were seven or eight of them. I had the joy of going to visit some of them and helping them train staff and organize. I got around the state and met the people who were coming into the field. It made me well-known. That's why they made me Commissioner when the governor suddenly needed to replace his current commissioner. Everybody knew me. I'd been around to help them set up. John was also active in starting the first rehab unit for alcoholic women at Central Islip state Hospital a few years later.

Retrospective of Professional Career

Bill White: You were at Central Islip from 1964 to 1979 and that really could be thought of as the period of emergence for modern addiction treatment, particularly modern alcoholism treatment. How did

treatment at Central Islip evolve through those years you were there?

Dr. Sheila Blume: When I took over the unit, the activities consisted of therapy groups, which were very large groups—so large I had to break them down into groups of eight to ten. We also had AA meetings twice a week led by community AA members on a voluntary basis. The wife of one of these AA members was just starting to set up an Al-Anon table during visiting hours. She took me to Al-Anon meetings, and I thought that was great. We pushed Al-Anon as hard as we could with visitors, but we never had Al-Anon meetings on the unit because we didn't think that was appropriate.

Ours was a rehab unit, and its patients were transferred from the hospital's admissions unit after they were detoxed. I used to go to the male admissions unit weekly and interview a long line (they literally stood in line and I was behind a small table) of alcoholic men who had voiced an interest in treatment in our rehab program. I had a limited number of spots to fill and at times it was difficult to choose between the candidates. I tried to include men who had had no previous treatment, but I also took a fair number of "old timers" to the system too, as they were a special challenge. Phenobarbital was the standard drug for detox at that time, and it's still a safe and effective treatment. I did not accept patients who also suffered from psychosis (who were later among the "dual diagnosis" patients, but did accept many suffering from depression and anxiety disorders. We had few psychoactive medicines to work with, and I used Librium at first as an anti-anxiety medicine, but soon discovered that one of my patients switched addictions, and after that I never again used any benzodiazepines for long-term treatment. I wrote a paper about that in 1967 (Blume, S.B.: "Some Unfortunate Consequences Following Use of Chlordiazepoxide (Librium) in Chronic Alcoholism." *Journal of the Central Islip State Hospital*, Vol. 1, No. 2, p. 15-19, 1967).

Bill White: In 1979, you took over the Director position for the New York State

Division of Alcoholism and Alcohol Abuse. How did that opportunity arise?

Dr. Sheila Blume: It arose because our Governor at the time was running for re-election and one of the main planks of his platform was reorganizing the Department of Mental Hygiene. Believe it or not, the Department of Mental Hygiene was the largest department in state government at that time. It had mental health, mental retardation, and alcoholism and it was just too big. The Governor cut it up into parts. The alcoholism part, of course, was very small, compared to the others, and there was a separate section created for drugs (meaning heroin addicts at that time) because the funding streams and facilities were separate at that time. We didn't have any particular feelings about that. We just ran our units separately and communicated. The Governor put one of his staff members in charge of the state's alcoholism agency, but he had some problems and decided to fire his commissioners. The alcoholism treatment unit staff members and members of the "alcoholism constituency" (insofar as it then existed in New York) were very angry. We were just getting going and had to face all that conflict. The Governor needed somebody to take over the agency and bring the alcoholism treatment people back together. They all knew me because I'd been around the state to help them, so he asked me to do that and I said okay.

Bill White: What do you feel best about during your years in that leadership role?

Dr. Sheila Blume: The people with whom I worked and the overall experience. It was all new. We had to improvise as we went along and that's so much better than having some holy script handed to you and being expected to follow it. We were setting up the system and if something didn't work, we tried another way. Many were very helpful but my deputy, Bob Ross, and Olive Jacob and Bob Matthews were particularly key staff members. And the people who were on in my Albany staff were *all* there because they wanted to be. They weren't old-timers who were just looking for a retirement date. They

were people with a deep interest so it was a real pleasure to work with them. We were responsible for all the alcohol units around the state, whose leaders I already knew. With all of the federal funding coming through to set up new programs, it was great.

Bill White: When you left that position in 1984, you went to South Oaks Hospital to direct their chemical dependency and compulsive gambling programs. How did you first get interested in the treatment of compulsive gambling?

Dr. Sheila Blume: I got interested in gambling much earlier through treating a patient who was both an alcoholic and a compulsive gambler. He was part of my Jewish alcoholic study and one of the people that I had studied in some depth. I really hadn't been aware that gambling was much of an activity for him but, when he stopped drinking, his gambling problems increased. After being sober for several years, he asked me if he could hide out in my unit because people he owed money to were looking for him and his life wasn't worth much if they found him. So I said, "Yeah, you can hide out in my unit." In those days, I could admit a person who hadn't had a drink in several years to my alcohol unit. I said, "But you're going to have to work on your gambling." And through him and (via the telephone directory) getting a member of Gamblers Anonymous to come over, I learned about GA and got him out to meetings.

When I left Albany, I retired from the state after twenty years of service. I really was looking to change to something else and South Oaks Hospital was in the private sector and looked like a good opportunity. It also had a training institute that I directed. It was really good for me: South Oaks liked me, and I liked South Oaks. They director, Pascuale (Pat) Carone, gave me a free hand. I eventually had one hundred and twenty-nine beds under my supervision. We had adolescent units. We had detox. We had rehab. We had a quarter-way house. We had intensive outpatient. We had regular outpatient. And we had great staff that we had trained ourselves in the training institute.

Many of them went on to get social work degrees and other degrees. It was a wonderful time. My deputy at the time was Bob Cahill, who was tremendously helpful.

Bill White: Over the span of these years, you were also doing presentations at innumerable conferences and in venues such as the Rutgers Summer School of Alcohol Studies. What recollections do you have of the years you trained at Rutgers?

Dr. Sheila Blume: I went first as a student to the summer school when I was starting out. I thought it was terrific and the next year, they asked me if I would teach at it. I became teacher instead of student. I'm sitting here next to a chair that says Rutgers University on it. That was presented to me on my fortieth year of teaching at the summer school. I stuck to it. I would drive out there in the summer for two weeks at first. Then, when I couldn't spare two weeks, I'd go for one week, and then I'd just give lectures. But I always kept my ties to Rutgers. It was an excellent place under Gail Milgram's leadership.

Evolution of Addiction Science

Bill White: Through your career, you also held a large number of editorial positions with such prominent journals as *Alcoholism: Clinical and Experimental Research*, *Journal of Psychiatric Treatment and Evaluation*, *Focus on Women*, *Journal of Studies on Alcohol*, and others. Given that experience, how would you describe the evolution of addiction science over the course of your career?

Dr. Sheila Blume: Well, I don't think we had anything that we could call an addiction science when you and I began work in this field. We were sharing our professional experience, which was very valuable for those of us who were out there alone in those early days. I would give talks, and I'd hear, for example, from somebody in a small town on the coast of Washington how much it meant to him to be able to talk to me and listen to me and read what I had written because he was the only person in this little

town trying to address the problems of alcoholism and drug addiction. He was responsible for everybody in the area who had a problem. So, we were sharing experience. That was what we had. I think the science came a lot later. Now, the science is growing but I don't think anybody shares much anymore. Maybe I'm wrong; I don't read the journals as much anymore. There seems to be less experience-sharing and more bean-counting. Now bean-counting can be very useful. I counted my share of beans. I love to write and I try to write papers in a style that anybody can understand, even though it's in a medical journal. You don't need any special vocabulary to understand what I have said or written, which is very good because it helped people in other countries. I would get letters from people in Eastern Europe, for example, reacting to something they read in an English journal and they would mention how they found it so helpful that I don't use technical language.

Psychodrama

Bill White: I'd like to explore some of the special interests within your career. During your early professional work, you were quite interested in the potential of psychodrama in the treatment of alcoholism. How did that interest develop?

Dr. Sheila Blume: Psychodrama is based on the work of Jacob L. Moreno. During his lifetime, he dominated the field. I found him to be a most interesting man. He couldn't walk into a room without drawing everyone's attention. He used to give public performances, if you can imagine such a thing. You'd pay your entrance fee and sit around the little arena with maybe fifty people in the audience, and he'd pick someone out of the audience and demonstrate this powerfully dramatic technique. When I first saw it, I said, "That's pretty good. Something interesting" and tucked it away. That was before I took over the alcohol unit at Central Islip. When I directed the alcohol unit, I knew we needed more than two group sessions and two AA sessions a week and I organized small

groups and decided to play around with some of the techniques I'd seen at that psychodrama. They were so useful that I started reading Moreno's books and went up for some weekend trainings that he ran at his place in Beacon, New York. I got to know the leading psychodrama people. I started demonstrating psychodrama at various addiction meetings and started writing about it in some of the addiction journals. Moreno's disciples used to gather every year in New York and he'd sit there like a great Buddha on the stage. He was a heavy man and people would line up and come up and do obeisance to the Buddha. He liked me because I was a psychiatrist. Most of his disciples were not physicians. He was an M.D. and a psychiatrist, and was very glad to have other psychiatrists at his side, so he gave me special privileges.

Treatment Needs of Women

Bill White: You referenced the special needs of addicted women earlier in the interview and you emerged as a real champion of gender-specific alcoholism treatment. What were some of the key milestones as the field began to address the special needs of women?

Dr. Sheila Blume: Well, one milestone comes quickly to mind, and I'm not sure how this happened, but NIAAA hosted a large national conference in 1980 on women and alcohol in Washington DC. They had asked several people to prepare in-depth papers, and these were put into a book, which I still have in my collection called, *Women and Alcohol*. I was asked to do the review of the literature on women and alcohol (a tall order indeed!) and they offered assistance in getting papers since this was the time before electronic searches and accessing papers through the Internet. People within NIAAA were so happy to have this happen that they did everything possible to help. I wrote this long review of the literature, which inevitably made me the guru on women and alcohol because it was so widely disseminated. I think that was a turning point. I'm not so sure it moved people who didn't care a fig about women, but it did give people who did care a

platform to work with in addressing the needs of women. I know from working within the state institutions that when you want to do something new, you better have something behind you other than just instinct. A book published by NIAAA was good to back up your desire to establish an alcoholism treatment program for women. People called on us all the time to write letters of support and I got many invitations to speak around the world because of this first seminal paper. I think this early work also contributed to NIAAA's subsequent decision to designate funds for women's treatment. Later, I was asked to speak on the subject at the NIH in Bethesda, Maryland. I later learned that one scientist saw the poster for my talk and asked herself, "What could there possibly be to say about women and alcohol?" Because she couldn't think of an answer, she came to the talk and approached me afterwards. She worked for the Journal of the American Medical Association, and was so impressed that she asked me if I'd write it up as a special report for the journal, which I did and it was published. After that, when anybody looked up the subject of women and alcohol or requested information about it from the National Clearinghouse, my JAMA article was sent out. That made me even better known internationally.

Children of Alcoholics

Bill White: A related area was your early writings on children of alcoholics. You were among the earliest professionals calling attention to the needs of these children. How did that interest develop?

Dr. Sheila Blume: That interest came out of my broader concern about the needs of families affected by addiction and the role I played in changing the language in the law that would allow us to provide services for families of alcoholics on New York. I've always cared about families because I always met them in my clinical work and could see their problems. In the early years of the field, there was nowhere to refer them to for appropriate help. The local mental health agency where they lived was staffed

with people with no special knowledge of addiction or interest in it. They would help them as best they could, but I felt one of the unmet needs of the field was a cadre of people with a special interest and expertise in family issues related to alcoholism. My interest in this area was also influenced by the work that Al-Anon was doing in this area.

Alcoholism in the Jewish Community

Bill White: Another issue that you took on that was quite a challenge was alcoholism in the Jewish community. Describe that and how you came to take that on.

Dr. Sheila Blume: Well, I just got ticked off at hearing from so many quarters that Jews were an example of a people who didn't become alcoholics. My reaction was, "Oh, give me a break!" I treated plenty of Jewish alcoholics in my day. I recall hearing this notion of Jewish invulnerability to alcoholism at a large national NCA [National Council on Alcoholism] meeting. I was with the psychologist who worked for me who happened to be a recovered alcoholic and Jewish and the two of us just got so angry, we said, "You know, we've got to do something about this." And I said, "Let's write a paper on Jewish alcoholics." So we made up a list of questions, a sort of semi-structured interview, and a check-off sheet so we could organize our data. Then every time we met a Jewish alcoholic, we'd say, "Would you mind being interviewed for this study?" Of course, everybody felt the same way we did so they were only too glad to cooperate and bring other Jewish alcoholics to the study. We put up notices about the study where we knew there were AA meetings being held. When we reached a hundred people in the study, we stopped and analyzed our data with the help of a colleague who knew more about statistics than we did. That paper was something of a breakthrough in rethinking the issue of Jewish alcoholism within the professional alcoholism community and in the Jewish community. Like the conference on women, it didn't make lightbulbs go off in the minds of people who had prejudices, and God knows there are plenty of them, but it was a

rallying point for people who were concerned about Jewish alcoholism. It sparked a lot of action.

The Treatment of Gambling Addiction

Bill White: Your work at South Oaks constituted a significant milestone in the history of gambling treatment in the U.S., including development of the South Oaks Gambling Screen. How was that instrument developed?

Dr. Sheila Blume: It was the project of Henry Lesieur. He'd been hired as a part-time consultant to get the study going. He was at that time a sociologist and professor at St. John's University in Queens, New York. He was one of the few professionals with an interest gambling addiction and had written his Ph.D. dissertation on this subject. An academic interest in gambling was very rare at that time. When the South Oaks gambling unit was first being organized, my predecessor contacted Henry to serve as a consultant, and Henry asked if he could have access to the patients to develop a screening tool. This was being negotiated when I took over the unit and I thought it was a great idea. Henry is a wonderful man and a very thorough and careful scientist. I worked on the clinical piece and Henry worked on the research piece. He became a student at our institute and became a certified addiction counselor, gambling being his specialty. We really helped one another out. He evolved from a sociologist to both a sociologist and clinician.

“Dual Diagnosis”

Bill White: You were among the earliest psychiatrists calling the field's attention to the needs of people with co-occurring addiction and psychiatric illness.

Dr. Sheila Blume: Yes. That was the beauty of being at South Oaks and how it differed from public facilities. In the government funding area, there were separate funding streams for mental health, for alcohol, and for drugs. Although alcohol and drug treatment funding was eventually integrated, they never got together with mental health.

So, in the public facilities, mental health came out of one pocket and had one staff and alcohol and drugs came out of another. People with both illnesses often got batted back and forth, and most addiction units did not even have psychiatrists except perhaps a consultant who came in once a month. This was a group that had no programming to address their special needs. They were either fish or fowl but they couldn't be both, but, in fact, they were both. So, one of the things I took advantage of at South Oaks was creating a place where dual diagnosis treatment was not only acceptable but the goal. We wanted to treat these conditions as a joint thing. Now over time that vision was compromised by the insurance industry. That great system of services at South Oaks suffered as insurance companies forced shortened lengths of stays and outpatient treatments that were very often clinically ineffective for dually diagnosed patients.

International Work

Bill White: What are your most vivid recollections of your international work?

Dr. Sheila Blume: Well, I don't know if you have ever had experience doing this—being called upon by other countries to give advice. It's a marvelous thing. First of all, it makes you into a figure of great wisdom, which you may or may not feel, but you have to play the role. And then having arrived and having taken stock of the situation as best you can, you have to remind yourself that do no harm is the first rule and go on from there. It's a back and forth and an up and down, but the one thing I never compromised was pointing out the need for equality for women, which I found almost nowhere. I can't remember anyplace I ever went that had equivalent facilities for women to those they had for men. So that was always part of my recommendation and most people took it.

Bill White: And what were some of the countries that you served in this way?

Dr. Sheila Blume: Israel and Iceland are the two that I remember the most. But a lot of the work in this area that I did was at international meetings.

Bill White: I also seem to recall you consulting in the Caribbean. What was that experience like?

Dr. Sheila Blume: That developed through the work of Michael Beaubrun. He was a remarkable man—a professor of psychiatry who had trained in Scotland before practicing in the Caribbean and serving as a professor at the University of the West Indies. Some federal block grant money was channeled to Virgin Islands, a US territory, and they didn't know what to do with it because they had no alcoholism services to invest in. So the money was used to bring in experts who could meet with the mental health and policy people about how to develop alcoholism services. I was asked to come down as one of those consultants by Michael Beaubrun and served as a co-director with him for several years in this effort. Every summer we provided alcoholism treatment training for people who came from all the English-speaking islands. We had a mixture of people, ranging from aides to upper-level administrators. That work spawned big changes in most of the English-speaking islands.

Career Reflections

Bill White: Given your long and varied career, what are some of the contribution or experiences you feel best about?

Dr. Sheila Blume: Personally, it's been just a tremendously interesting and rewarding career. I worked like a dog and I really mean that. I never had time to answer correspondence at work so I always did that at home. When I got the kids to bed, I'd prop myself up in bed with a nightlight and do all my correspondence, and when I'd finish that, I would write papers, and then wake up mornings and finish writing the paper before going to work. It was a lot of hard work, but very, very rewarding. There were various kinds of people who profited from what I did, particularly the patients and their families. We always had reunions at my hospital where former patients would come back with their families, and those were such happy events. We had sort of a buffet dinner that

the state hospital would put on for us and my favorite moment was when I would say, "Would everyone who is a graduate from our alcoholism program please raise your hand?" You would look around and see a hundred and fifty hands were in the air. It was just so marvelous. Everyone would break into cheers and applause. Others were the professionals whom I trained and the letters and calls from people in the field who were always grateful to get answers to their questions. When I was in government, I was part of changing laws that I think really made a difference, like the change in the minimum drinking age in New York. I worked hard on that and it was wonderful to see it pass and go into effect. I just have had a wonderful ride.

Bill White: Is there any advice you would have for a person who today may be considering a career in addiction medicine or addiction psychiatry?

Dr. Sheila Blume: Yes, I think there are plenty of unmet needs if somebody has the motivation to change things. This is a good field to be in if you care deeply about the issue and you're willing to work at it. There's still room for improvement and room for new ideas and approaches. We need people who will carry this work forward.

Bill White: Finally, who are some of the people who most influenced you during the course of your career or who you think have made significant contributions to the advancement of addiction treatment?

Dr. Sheila Blume: In addition to the people I have already mentioned, the first two alcoholism counselors hired by the state of New York, Howard Straub and Art Branston, should be recognized. They did a lot to shape our early programming. Also there were all of my colleagues in ASAM (the American Society of Addiction Medicine) and those who helped get the APA (American Psychiatric Association) to develop a special and support councils for addictions. Migs Woodside of the Children of Alcoholics Foundation did so much to publicize the needs of that population and to stimulate

research. There are so many other physicians who might be internists such as Max Schneider or Stanley Gitlow, or psychiatrists such as Ruth Fox, who were active in forming the field. Now the next generation of physicians like Stu Gitlow (Stan's son), and so many others, have taken their turn at the helm. I'd also like to mention those who worked to develop workplace addiction programs, especially those for impaired physicians and other professionals, which have been such a success. I worked on those in New York State and know how much cooperation is needed to launch and run such a program. Finally, there were philanthropists, like Brinkley Smithers, who supported programs and research.

Bill White: Dr. Blume, thank you for taking this time to reflect on your career in addiction psychiatry, and thank you for all you have done for people seeking recovery from addiction.

Dr. Shelia Blume: It's been a pleasure, Bill.

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Further Reading

Blume SB (Journal Interview #75):
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