Conversation with Jonathan Chick

In this occasional series, we record the views and personal experiences of people who have especially contributed to the evolution of ideas in the journal’s field of interest. Professor Jonathan Chick is now retired from a long and successful career as a clinician in addiction psychiatry for the National Health Service (NHS) in Scotland. He was formerly consultant psychiatrist at the Royal Edinburgh Hospital and senior lecturer at Edinburgh University. His career as an academic and as a renowned clinician in the field of alcohol dependence continues, with his most recent appointments being as a Professor at Queen Margaret’s University in Edinburgh and as a Medical Director at Castle Craig Hospital. He is an author and editor of many books and articles concerning the prevention and treatment of alcohol problems. Professor Chick is also editor of *Alcohol and Alcoholism*.

**EARLY LIFE AND INFLUENCES**

*Addiction (A):* Tell me about early influences on your interest in science and medicine and childhood experiences that may have influenced your career choice—if you are willing.

*Jonathan Chick (JC):* I was blessed to be brought into a very stable and happy family, where I was the third of four children. My father was a career Naval Officer and a remarkable engineer and was very keen to help me whenever we had a physics or a maths problem to deal with from school. My parents were strong Methodists—not in a very florid way—they were not teetotal, but they were good and very active in the Church and looked after all kinds of lame animals in the Church or elsewhere in the community. We were used to having people visiting the house who needed a little extra help, so I suppose I was fortunate to absorb a little bit of both parents’ caring attitudes. Alcohol was not present at any Church function, but certainly in my parents’ social life it was quite important. In retrospect, there were at least two alcoholics—both doctors—who were family friends of my parents, one of whom committed suicide and another died young, but I only ever realized the meaning of these tragedies later in my life. My parents would serve alcohol in a limited way, but I knew that sometimes if they held a party there were one or two people—strangely doctors—who would be quite drunk at this party. My mother’s mother may have been in a temperance movement in the early 1900s but certainly, at the time she died in her 94th year, she was having a glass of sherry.

The only medical person in our family tree was Dame Harriet Chick, whom I knew up until the time of her death at the age of 104. She devoted her life to medical research, and her name is known both in bacteriology and in the wonderful serendipitous story of the discovery of vitamin D. She was an iconic figure when I started to study science and then psychology, and because she lived in Cambridge I got to know her and her very modest account of her life, which had included going to Vienna in 1918 or 1919, when much of Europe was in famine. These were some influences that might have led me into medicine, perhaps, but most of all I think it was the realization that studying chemical engineering, which I had set out to do at Cambridge, was not going to be nearly so interesting as taking up experimental psychology, to which I switched, and that led me later to look into the possibility of going to medical school with a view to studying psychiatry.

*A: Can you tell me more of these influences on your career prior to medicine?*

*JC: When I was studying psychology I became fascinated by psychopathology and its causes and manifestations, and I was very fortunate to be given a link that led me to some new developments. I was a very young student at that time, but I had an offer of a brief job as a social therapist at a hospital that had become famous for its therapeutic community back in the 1950s and 1960s. This was Dingleton Hospital, in the Scottish Borders, where a sort of hospital democracy functioned. From Dingleton I was linked to visit a project in Paris, where the
13th Arrondissement, the local Council and the sector psychiatrist decided that they would close the beds allocated to them in St Anne’s Asylum and use the funds to build a very small new hospital in the suburbs coupled to day-, out-patient and hostel facilities for their psychiatric population. This was in the early 1960s, when it was innovative, and, indeed, I was very surprised after I had written it up to receive a telephone call from Hugh Freeman, who was Editor of the British Journal of Psychiatry, who said: ‘I hear you’re a student who has actually done some research on the Thirteenth Arrondissement Project’. This became my first ever publication in a glorious tome of weighty papers, edited by Hugh Freeman [1]. I wrote about how they had gone about the project in Paris and I collected data about whether they had succeeded in preventing the development of chronic illness by withholding institutional life. I saw the advantages and pitfalls of trying to manage serious mental illness in the community, and there were alcoholics among the patients who were being looked after. I suspect that was formative, not only in interesting me in psychiatry outside the institution but also in looking at how imaginative services could use the local facilities and local community organizations to help a defined population care for its mentally ill.

A: Were you able to make use of this experience in your career? 
JC: I was not very conscious of its influence at any time, but I suspect strongly that my first psychiatry post, as a senior house officer to Dr Bruce Ritson, reinforced the experience, because Bruce had just come back from Boston, where he had been doing something very similar [2]. The consultant post that Bruce and others created at the Royal Edinburgh Hospital, which I was fortunate enough, subsequently, to apply for and enter, brought the services much more into the community using local resources.

**EARLY MEDICAL CAREER: UNDERGRADUATE MEDICINE**

A: Tell me about Edinburgh University Medical School and your experience there in the late 1960s/early 1970s? 
JC: Well, my flat was above a hostelry that used to be called ‘The Mortar’ because it was associated with the medical school, which was 50 yards away and also close to the main hospital. That pub was later renamed ‘The Doctors’, but I do not seem to think that there was a great deal of drinking at the time. It was very expensive, and a pint of beer on a Friday night seemed to last a very long time when you were paying out of your student grant for it.

The alcohol problem service at the hospital, where I went as a student to train in psychiatry, had grown out of probably the second in-patient unit started in the United Kingdom for alcohol problems. Started by Professor Henry Walton, the tradition there was psychodynamic. It was felt that for many of the sorts of people who came to the clinic, alcohol had been their way of dealing with sometimes barely conscious emotional conflicts. Nevertheless, with the time, those clinics were changing quite a lot and certainly, when Bruce Ritson took over, he had experience in community psychiatry and wanted to widen the admission criteria to this rather select 8–10 weeks in-patient psychotherapy unit.

There was certainly an alcohol-related medical event which stands out in my mind. I had been one of the early readers of The Divided Self by R. D. Laing and suggested to the Medical Students’ Council that we invite Laing to give the Annual British Medical Association Medical Students Lecture. I have a very vivid image of helping R. D. Laing off the train from London, on which he had consumed a considerable amount of champagne, and then helping him to the lecture theatre, where the great and good of psychology, medicine and sociology at Edinburgh University had gathered. As is known from some of his writings, he could be quite impudent about establishment medicine and he proceeded in a demonstration of that by, with slurred speech, taking off most of the upper items of his clothing while he told us that he had just had his 40th birthday. As readers may know, R. D. Laing and the anti-psychiatry movement at the time had some very serious points to make about family influences. The tawdry secrets of the family had been a BBC Lecture a few years before and one of the secret, or not so secret, points in his family had been that Ronnie always took after his uncle, who had died of alcoholism in his 40s or thereabouts, and so it was significant when he told us ‘yes, I’ve just had my 40th birthday’. Meanwhile, several of the senior members of the psychiatric establishment had already left the lecture hall in disapproval.

**POSTGRADUATE CAREER**

A: Beyond your medical school years, you stayed in Edinburgh and entered various training posts. Was it your intention initially to specialize in psychiatry? 
JC: Actually, I had come to medical school already thinking that psychiatry was what I wanted to do, but the teaching in Edinburgh was so good that I became interested in just about everything that was going on and, for a time, I headed into neurology and performed some neurosurgery for a short period. Finishing my first degree in experimental psychology had stimulated my interest in studying medicine.

Alcoholism did not, at that time, come into my domain. Rather, I was still fascinated by how people could become schizophrenic and what that illness could consist
of. My alcohol interest arose through taking a post with Norman Kreitman, a very clear-thinking psychiatric epidemiologist, who was directing a Medical Research Council (MRC) unit, and when I applied to join him he said: ‘You can either work on suicide and attempted suicide or alcohol problems. That’s your choice.’

A: Which did you choose?

JC: It was alcohol problems that caught my interest, already partly because of the social aspects of alcohol and its problems and, I think, probably influenced by one or two patients that by that time I had been seeing and treating, and I could see that although I was going to be working on survey work and alcohol problems in the general population for the MRC unit at a clinical level, these were a very interesting group of people who had a severe illness from which it was possible to make a complete recovery.

CONSULTANT POST

A: What was the next step in your career? Tell me about the transition from working with the epidemiological unit into your next post, which was your post for 31 years, being a consultant psychiatrist at the Royal Edinburgh Hospital. Was your initial post alcohol-specific?

JC: I was very fortunate that at the time when I might be looking for a consultant post, a new post was created that was intended to develop out-patient and community services. Having just completed a survey of heavy drinkers among the working population, I could see the preventive and early work that could be conducted in the alcohol field.

It was almost full-time in alcohol, although the tradition was to keep some sessions in general psychiatry, and I had one or two sessions helping with the Learning Disability Service. One of the exciting developments at that time was to formalize the out-patient withdrawal regimen. It seemed to be regarded as too risky to offer medications to alcoholics who were going to go home. ‘Wouldn’t they just drink on it? Wouldn’t they take all their capsules? Surely, to withdraw from alcohol you needed to be in an almost restrained environment?’ Now, it may be that we began to see earlier and less severely affected people, but I think what we started doing was making quite a structured arrangement. We insisted we would only issue medication for 24 hours. We insisted we would see the patient every day. We were already using breathalysers regularly and little by little, of course, this became widespread.

ALCOHOL SPECIALISM

A: Over these years in your clinical practice you focused on alcohol, but these days services and specialists tend to be generic. Did the world of drug misuse and dependence intrude much into your clinical practice?

JC: Drug abuse was much, much less frequent than now. It was only when Dr Roy Robertson, an Edinburgh general practitioner (GP), in the 1980s began systematically collecting blood samples from injecting drug users who happened to find their way to his clinic, that we were galvanized to do something in Edinburgh about drug problems. He had been looking for viral liver infection, but noticed reports from elsewhere about HIV, went back to his samples and announced to the Edinburgh population that 50% of injecting users were HIV-positive. There was a panic among middle-class Edinburgh that their teenage children might somehow be exposed to the HIV infection. Edinburgh had to urgently put together a drug treatment service. This was set up separately from the alcohol service and I was glad to help, but not actually invite this work into our own clinic.

A: Do you think there should be separate streams of service and separate clinics for people with alcohol and drug problems?

JC: Over the years, we began to see more patients who used drugs as well as alcohol, and I did not have a problem in trying to help them deal with whatever aspect of their addictions they thought was the most important for them to deal with and, of course, sometimes we could deal with two or three addictions all at the one time. With regard to my own out-patient clinic, I felt the ambience of the clinic was very important to people coming for the first or second time, ambivalent about their alcoholism, and I wanted to keep these populations a little bit separate. In Edinburgh there was far more stigma attached to drug problems, and the drug addicts’ behaviour was often much more difficult to manage in out-patient clinics. Separate clinics seemed best at that time.

COMORBIDITY

A: The other interesting interface is between alcohol or drug services and mental health services. In these years of practice, were there any difficulties in that interface? What, in general, was your take on mental health in relation to alcohol problems?

JC: Perhaps, rather arrogantly, I used to think that we psychiatrists were absolutely the right people to be looking after these folks. We understood about their medical problems, we could give them advice on their blood pressure or their liver situation. We could also understand when they talked about depression, anxiety, hallucinations, delusions. We were the right people to be dealing with these folks. At its extreme, of course, we were not experienced enough in managing the very severe and recalcitrant schizophrenia among a few patients and so we would work in tandem with the psy-
chosis services but we, and our trainees, were psychiatrists. We tried to help our trainees not to slip into continually referring on.

One of the tragedies for many families where there have been alcohol problems is the loss of the motivation of family and patient when they are handed on from service to service. The research literature is very clear about how often these psychiatric conditions can overlap. The available treatments may, for some patients, be antidepressants if they have a primary depressive illness, but the alcohol problem itself must be completely assessed in the forefront of the patient’s and physician’s mind in trying to help such a patient with a mood disorder.

INCREASING PREVALENCE

A: You chaired the Scottish Intercollegiate Guidelines Network (SIGN) Guideline for General Practitioners in their management of alcohol problems in their patients[3]. I see the SIGN Guideline as an attempt to deal with increasing numbers with alcohol use disorders. What was the impact on your service of this upward trend?

JC: There was a tradition in the Edinburgh Alcohol Service, going back to the 1960s, of specialist nurses and our own nurse, who did our screening and intervention in the general hospital in the early 1980s, was an alcohol specialist nurse. We quite quickly appointed first one and then two community nurses in alcohol and they were very expert in managing detoxification. They knew when the timing was right to raise the possibility of Antabuse with a severely relapsing patient. As time went on they could have the understanding of the use of naltrexone or acamprosate as well as running their own individual or often group social skills therapies. We had a great tradition of occupational therapists who were very practical and skills-orientated and, to me, we kept pace for many years with the growing demands on the specialist service.

It is quite embarrassing now to hear about waiting lists at the specialist services, which was something that seemed to me, even 10 years ago, we did not have. I think Scotland has done well in establishing the role of specialist drug and alcohol nurses. I have a feeling we might have been the first to have such a specifically designated post, and it has been wonderful to see how acute hospitals around the United Kingdom have taken up this notion.

TREATMENT EFFICACY

A: Reflecting on this sustained interest in treating people with alcohol problems clinically over 30 years, what would you say to people who say ‘well, people with alcohol problems—it’s quite a demoralizing field to be in. You do not see a lot of change, you do not see a lot of benefit.’ What would be your quick response in a taxi-cab conversation?

JC: I would say that some of the most rewarding moments in my career as a doctor have been meeting the patient or a member of the family a few years later, barely recognizing them across a crowded street or in a theatre foyer or as a taxi driver behind his wheel and hearing from them how their lives have completely turned around, how they have made a new start and how the help that they received, not just from me but from the range of helpers out there—often, of course, perhaps including Alcoholics Anonymous (AA)—made a difference. This is the most rewarding thing a doctor could expect. While I realize that stroke victims and cancer victims can be helped, there is a great deal of work to be done. Some of the greatest recoveries are in addictions, where you see a potentially fatal situation being turned around by a combination of an individual’s determination and their friends, family and the little bit that we can add into all that.

SCOTLAND AND MINIMAL UNIT PRICING

A: I know you have retired from the National Health Service (NHS), but you remain very much involved in the field of alcohol research. Can you tell me about your current work?

JC: I have become very interested in the Scottish situation with regard to alcohol problems, which has shown an embarrassing acceleration of prevalence of and, indeed, mortality, from alcohol problems. I had realized that we were in an unusual position about 10 or 15 years ago and put together a piece about the rising hospital admission rates and mortality rates. This was published in a local publication called The Health Bulletin, which was really a sort of Scottish Health Department journal[4]. I was very pleased that afterwards I was invited, for the first time, to the hallowed halls of St Andrew’s House, the beautiful 1930s art deco government buildings in Edinburgh, to talk about the meaning and possible causes of this acceleration of the Scottish figures in comparison with other European figures. Scotland certainly has moved on and my current research is in relation to the impending price changes. Scotland may become one of the first nations to implement a minimum price per unit of alcohol. Now that was certainly not my concept at all, although it was a concept of colleagues, I believe colleagues such as Bruce Ritson, Peter Rice and Peter Brunt, who convened a meeting at the Royal College of Physicians of Edinburgh some 8 years ago.

The current research builds on a pilot study we conducted of the purchasing habits, price and location of
purchasing by patients known to the services in Edinburgh who were ill with alcohol: medical, surgical, psychiatric, social ills [5]; we are now collecting a new cohort that we will follow-up for a year in the period leading up to the implementation of a minimum price, and then we will try to keep in touch with them in the period after minimum pricing to see how this has affected their purchasing of alcohol and whether they have turned to substitute intoxicants. Many of these drinkers will have to find quite a considerable amount more money to continue purchasing the same quantities of alcohol that they are drinking at this time. We are glad that we have been able to find funding to follow a cohort recruited in the same way in Newcastle clinics and hospitals, because South of the border it is unlikely that there will be an implemented minimum price of alcohol. Thus, we have a sort of naturalistic control group.

For some reason, the matter of the price of alcohol did not used to strike me as that important but I do recall, about 8 years ago, seeing a learning disabled man, about whom I knew the history, standing outside an off-licence. I was with a colleague who had been treating him for his repetitive paedophiliac sexual offending. He was a very frequent attender at court, to do with standing at primary schools exposing himself, and all his offences were under the influence of alcohol. There he was at 10 o’clock in the morning with his purchase of four 3-litre bottles of cider and he was starting to drink it on the pavement, using his incapacity benefit money.

**GUIDELINES WORK**

A: Looking back within the Scottish context, you had a great deal of influence on two major streams of work that came centrally to guide us within the Scottish Health Service. One was the SIGN Guideline on the management of alcohol misuse and dependence in primary care [3] and the other was the Health Technology Assessment of treatments for alcohol dependence [6]. Taking them in turn, can you tell me how you came to be involved, how you came to have a leadership role with these projects and what you feel are the abiding legacies of these projects?

JC: Scotland developed a wonderful collaboration, funded by government but run by the Royal Colleges, particularly the Royal College of Physicians, for producing high-quality clinical guidelines. These were among the first of internationally recognized guidelines that began to be produced in the 1990s using strict criteria, and expressing the quality of the evidence and enabling readers to see how the guidelines had evolved and been rated. However, nowhere to be seen was anything to do with alcohol. At that time you had to make a case. You had to go to the SIGN Committee and argue that the condition or illness that you were interested in deserved a guideline and that there was sufficient literature for its hard-headed statisticians to get their heads around and examine. At the time, it was generally dismissed. There is no such literature for alcohol. Everybody knows we were told that alcohol research is crippled from the start, because it relies upon self-report and no drinker will ever report accurately, so any data you have about alcohol problems are not going to stand the test of quality allocation. We got through that hoop by bringing along reports on treatment outcomes and studies that had been conducted and then it was a great privilege to work with this group, the technicians from SIGN, and the wonderful group with a lay member: a splendid gentleman recovering from his alcohol problem, who was an extremely astute reader, both of the literature and what we were producing, as well as colleagues from primary care and specialties. That was directed at primary care: what evidence there might be for action on alcohol problems in primary care and in general medicine.

We did not tackle, specifically, the treatments that were available to specialists and so, within a year or so, we were approached by a Health Technology Group that had been set up separately by the Scottish government, who had by that time just produced two Health Technology Assessments, one on breast cancer and one on an aspect of diabetes management; we were quite proud that they were going to make their third topic alcohol dependence, and that this would now include health economic evaluation. The SIGN guidelines never went into the health economics and relative costs of what the guidance was, but the Health Technology Group was to look specifically at the cost-effectiveness. It was predicated on an assumption that if someone could achieve abstinence for 1 year and then sustain that, what would be the cost saving to the Health Service, because that individual would not need a liver transplant, would not cost saving to the Health Service, because that individual would not need a liver transplant, would not repeatedly re-enter hospital, would not cause cost in the criminal justice system.

Of course, that was an assumption, and we know that 1 year of sobriety is a helpful predictor to future outcome but not an absolute predictor of future abstinence. Nevertheless, we made that assumption to facilitate the work of the health economists, and the results were quite amazing. We realized that treatments for alcohol problems could have a negative cost; in other words, a cost saving. A treatment that could cost £10 000, if it was effective, could then save the Health Service £10 000 because alcohol-related harms end up being very expensive to the Health Service, as these economists were able to show, by going into Scottish health statistics and demonstrating that treatments such as group-based social skills relapse prevention training and even relatively
costly drugs, such as acamprosate or supervised disulfiram, could produce these actual cost savings overall to the Health Service.

ALCOHOL BRIEF INTERVENTIONS

A: One other big new initiative in Scotland in the past few years has been to deliver alcohol brief interventions through primary care. There is some debate about whether this can also reach into accident and emergency, antenatal services and the criminal justice system. Some of your earliest research was around delivering brief interventions for alcohol. What is your perspective on this recent country-wide initiative?

JC: The work that we carried out was in the Royal Infirmary medical wards in the early 1980s, where we screened all patients able and agreeing to participate, to pick up people who had alcohol consumption above a certain level and/or who were reporting an alcohol-related problem. This was a group who were, by definition, concerned about their health. They were actually in hospital beds at the time, not necessarily for alcohol or not that they knew it was alcohol-related. It might have been for assessment of high blood pressure or because of a complication such as a peptic ulcer bleed, but they were concerned about their health. This group responded to an up to 1-hour discussion with a nurse, compared with the screening interview only. When we followed them up a year later we saw this advantage in terms of gamma-glutamyl transpeptidase (gamma-GT), and the alcohol problems accumulated in the coming year.

The main research has subsequently been in primary care, and not always taking patients who are concerned about their health. Often, all-comers into the practice are screened. Now, overall, as the meta-analyses show, there are sufficient data to encourage the use of screening and brief intervention. The intervention can be as brief as 10–15 minutes.

The Scottish government, I think, were the first government in the world to actually fund GPs to carry out this work. It had often been shown in specialist projects that with well-motivated doctors who had especially signed up to do this work you could demonstrate good effect, but whenever people took it out into a more routine setting it seemed to lose some of its power. The Scottish government financial incentive has increased the number of screenings and brief interventions carried out here. Sadly, it will be quite hard to evaluate specifically the effect of this nation-wide implementation.

We did, certainly locally, set up a protocol whereby the interventions were mainly for people who had at least one of a number of possibly related social or medical markers which would have helped to make the intervention more likely to be effective, but different areas of Scotland have been allowed to create their own protocols for how this is carried out and how the payments are made to the GPs. I have had varying feedback when I have spoken to GPs about this. Some have felt, just as we knew from the research, that patients were going to be a little upset if the alcohol matter had been raised completely out of the blue in a consultation that was for something totally unrelated, whereas other GPs have been glad to be able to say to patients: ‘Look, this is now part of what we do. We are required to do this and I hope you can see the meaning of this, in our Scottish context, that we are now asking all our patients about their drinking patterns.’

It is too early to tell whether this will have contributed to Scotland’s overall strategy to deal with its alcohol problem, but there is no question that a great deal of screening and brief intervention has been conducted in Scotland in the last 3 years, and quite a bit of money handed over to GPs, who are quite happy about that.

ALCOHOL AND ALCOHOLISM/ALCOHOL RESEARCH

A: At the current time you are the Editor of Alcohol and Alcoholism (OUP/MCA Journal). Can you tell us how you came to be involved with that role and your perspective on the health of alcohol research at this time from the Editor’s viewpoint?

JC: It is a great privilege to be at the helm of a respected and well-established medical journal. I have not quite felt the pain doing the job which you might expect if you read a letter that Charles Darwin received from one of his friends at the time he took up the post as Editor of the Journal of Entomology: ‘Dear Charles, I am very sorry to hear that you have become an Editor . . . It may bring you much unhappiness.’

I am not sure if I have lost any friends by doing this job, but occasionally there are difficult decisions and there are people who have worked very hard on a piece of work who cannot satisfy our critical reviewers, and we have to refuse to publish. At the point at which I had the privilege of taking over as the Medical Council on Alcohol’s Chief Editor it had already achieved a status for biomedical papers, but many of the readers felt that the weight was too biological and not clinical and social enough for their tastes and needs, and so we have been able to alter that balance: I hope we have got it right.

A: As Editor, obviously you are in a very central position to see how this specialist field of treatment of alcohol problems might be progressing. Do you think there is anything on the horizon that will have a major impact on our ability to help people with alcohol problems?
JC: I fear that I am rather a reductionist thinker and cannot claim to be a lateral or innovative thinker. I still hold hopes for progress in genetic studies. I realize that at the moment we have only one faint glimmer where we can relate a specific treatment—e.g. opiate antagonists—to a specific gene type, and that is still not a very robust finding.

However, in the future, I believe that there will be some people with a strong genetic loading who will be able to manage alcohol in their lives using a specifically tailored pharmacotherapy. Most of the people we see, of course, do not think immediately of pharmacotherapy for their alcoholism until they have tried and exhausted all the social and psychological, spiritual and philosophical approaches that they can master, and at that point we know there are people who are extremely grateful for a chemical modification of something that lies quite deeply in the way they handle situations and interact with the environment.

A: When you look back at your research career what, for you, are the standout studies in which you were involved?

JC: Norman Kreitman encouraged me to analyse in detail the claims about alcohol dependence as a syndrome, and it was possible to show the sequential development that symptoms would tend to follow [7–9]. It was certainly possible to show that symptoms clustered together, and we saw the problems that alcohol caused in social or medical parameters as a sort of orthogonal dimension to dependence. We could see that there were some dependent people who did not have such problems. We could also see people who were accumulating quite a few problems who did not have the features of that syndrome. Now, of course, there is doubt about separating out dependence in this sense, and in DSM-V and ICD-11 we will have a one-dimensional concept, namely, alcohol use disorder, along which there will be a possibility of accumulating numbers of symptoms and signs, thus a sort of degree of severity.

I suspect that at the severe end it will greatly resemble alcohol dependence as we knew it, plus some of those problems that we previously separated out. I think, in clinical use, the alcohol use disorder concept will be far more practical and will not lead us into a situation where studies had to be conducted ‘in alcohol-dependent individuals’, and somehow not in others who did not have those criteria, whereas in real clinical life you want to be able to apply a treatment that can meet the needs of people all along that continuum. Also, clinicians will still, for management purposes, need to separate out those who are going to develop serious withdrawal symptoms, and of course it will be possible that clinicians will do the same as they did before and say: ‘this individual with an alcohol use disorder has symptoms of physiological dependence which will need to be managed during withdrawal’.

A: What are your main outside interests?

JC: Music is such a joy. It is also a mental exercise of a different sort to that of editing a journal! I sing in two choirs: church and operatic. There is a social aspect to a choir, too. However, like the piano, it demands regular practice. The chance to join a stage choir last August reawakened a latent interest in theatre—the choir was integral to David Greig’s new Edinburgh Fringe play about the stages a community goes through after a horrendous tragedy such as a terrorist massacre.

A: What advice would you give a young researcher starting out today?

JC: It used to be said that the most important step by a researcher in addictions would be to leave the field before his or her reputation was forever tarnished. This was predicated on the assumption that the patients would lie, and therefore outcome data were inevitably unreliable. Actually, we have more objective outcomes data (biomarkers of alcohol and drug use) than are available for most other psychological conditions. So it is a robust field to join.

A: Thank you.

Note

The opinions expressed in this interview reflect the views of the interviewee and are not meant to represent the opinions or official positions of any institution or organization the interviewee serves or has served.

References

