**Andrew Tuttle**

**Narrator**

**Amy Sullivan**

**Interviewer**

**February 16, 2017**

**Wettingen, Switzerland**

Andrew Tuttle -**AT**

Amy Sullivan -**AS**

**AS:** We are in Baden?

**AT:** We’re in Wettingen.

**AS:** Wettingen.

**AT:** Next to Baden.

**AS:** Today is February 16, 2017. This is Amy Sullivan. I’m with Dr. Andrew Tuttle. Would you just say your name?

**AT:** My name is Andrew Tuttle. I explicitly give Ms. Amy Sullivan permission to record what I’m saying.

**AS:** Thank you. I wonder if this is picking you up. I might put it on top of this, is that okay?

**AT:** Sure.

**AS:** What I was telling you earlier is I like to start with your childhood, where you grew up, your family, some of your childhood experiences. How you ended up here, where you were born, stuff like that.

**AT:** Do you want me to just go? Okay. I was born in Minneapolis in 1952. I was the only child of my parents then. We lived on Oliver Avenue in Kenwood in Minneapolis. It was a nice, modest house there. My father worked in the M.A. Gedney pickle packaging company. He later becomes the CEO. My mother then was not employed. She was a mother and a housewife as much as I remember. She had been to college and was a very well educated person. She’d gone to college. She majored in English literature. She was very well read and well spoken.

**AS:** Where did your folks meet?

**AT:** I don’t know. I think it was a family thing. The parents on my mother side belonged to a certain social circle that knew each other. As well as my grandparents went to places like Minikahda Club. Somehow a connection occurred there. My knowledge of exactly how that occurred is kind of sketchy. Now my father has died. Anyways, the way I remember those first years is rather difficult. I have nice memories. My father and my mother and being tickled and stuff like that. But I also remember them fighting viciously, verbally.

**AS:** Even as a young kid?

**AT:** As a very young kid. I think this was at a stage where I hadn’t completely stopped wearing diapers, two or three or something like that. Definitely before kindergarten. I have scenes in my head of standing at the top of the stairs just watching my parents just rip each other’s throat out.

**AS:** Were they physically abusive?

**AT:** No. It was verbally. I was a difficult child. Retrospectively I most certainly had ADHD. I was unmanageable. My parents constantly got calls from kindergarten. Later on I spent most of the time in the principal’s office in grade school. I was disruptive. Give me a hammer I’ll attack the front walkway of our house and see how easy it is to break concrete apart. Bicycles, or a car I can let the air out of the tires. I was a troublemaker. I got into fights and was just hyperactive. I was all over the place.

**AS:** Were you still watching your parents fight at this point?

**AT:** That’s not that central. More central is the way that I met disapproval with adults. Actually kids of my own age who knew that they could get me to do stuff. Then they’d go tell on me.

**AS:** You were that kid.

**AT:** It was kind of a formative experience because I felt myself being that troublemaker and that guy who could never do something right. I think fortunately I was intelligent and could pick things up quickly. I remember my dad once, this must have been before I was six and half or seven years old because that’s when we moved to California, he was just absolutely beside himself because I’d taken some tools and taken his bicycle apart. That’s kind of a memory I can chuckle about now but at the time it was, “I’m just trying out these tools. Why are you mad at me?” We moved to California before I was seven or after seven. I had just started first grade in Minneapolis and we moved to California and I continued first grade there. We lived in Berkeley where my mother worked. This was after my parents got divorced.

**AS:** When did they get divorced?

**AT:** They got divorced in Minneapolis. Just after they got divorced my mother moved with me to California where her parents had moved to previously.

**AS:** Your father didn’t move to California?

**AT:** No, this was just my mother. I moved with her to California. First we stayed with my grandparents there, my aunt and uncle who were still adolescents at that time. A very big age difference between my mother and her sister and her much, much younger brother who was four years older than me. He wasn’t even in his teens when we moved there. He was still a kid.

We quickly moved to Berkeley where we had an apartment. My mother worked in the Lawrence   
Radiation Laboratory up on the hills of Berkeley as a librarian. That’s where she met my later step-father who was working there as a nuclear physicist. They had a relationship, got married, and in 1962 we moved to Switzerland which was an adventure in itself. We came by boat from San Francisco. A steamer that went through the Panama Canal and across the Atlantic Ocean and across France with a steam engine.

**AS:** Was he Swiss?

**AT:** No he was German, from Munich.

**AS:** Is your mom American?

**AT:** Yes. So is my dad. My mom had her roots in Ireland and Scotland. My dad’s ancestors come from Southern England.

Anyway, we got to Switzerland and I was nine years old. I have a late birthday in December. I’m actually a year younger than the year I’m living in. I became ten in that year but we moved here in Spring. We very quickly moved to a very small farm village in Switzerland where I was in school with the only Swiss students, pupils. It was still an adventure because here I’d come from urban Berkeley to this tiny Swiss village where most of the kids who came to school were farm kids. After school we could wander over to the farm. We could watch their parents milking the cows and help them gather cut grass from the fields to feed the cows with. I just thought it was really cool. Within a three minute walk you could be in the woods and the forest. If you walked you would come to a little lake and you could go swimming there and jump off the limbs of trees into the water. It was cool.

My stepfather was a passionate mountaineer. I have to credit him with introducing me to the Alps. We did a lot of Alpine tours and not actual climbing but long, long several day tours up high over glaciers and staying in Alpine cabins. That’s where I gained my own passion. Later on I became a rock climber and did a lot of rock climbing and mountain climbing and stuff like that. I still love going up in the mountains and taking long hikes. He was also a difficult guy and my mother was a difficult person. She was the central person for me throughout my childhood, right up to my early twenties, I was very focused on her and very emotionally. She was the person I’d lived with all my life. Only now with a certain temporal distance and knowing what I know about psychology and dealing with life myself, I know that she was a very, very emotionally difficult person. One that could get somebody to fight with her. They did. With my stepfather it became physically violent. I witnessed her being beat up a lot. He was a brilliant scientist, well liked.

**AS:** Did he work at the technical place?

**AT:** He worked in conjunction with the Swiss Institute of Technology. He was building what today is known as the Pau Scherrer Institute. Then it was the Swiss Institute for Nuclear Research. A short way from here they constructed a cyclotron and now they have a bevatron and a synchrotron. It’s a big nuclear research facility that he oversaw the development and construction of. He was a prominent physicist in his field then. He also drank pretty heavily. They fought viciously almost every night. Occasionally it would escalate to physical.

**AS:** By this time, you’re ten? Eleven? Was this happening when you had moved here or was it before?

**AT:** They were verbally fighting before. Right from the outset they were verbally fighting. I did not enjoy all of the stress. In my mid-teens I started detaching myself from them.

**AS:** They stayed together?

**AT:** Yes, she had three more children by him. Three half-sisters of mine. The middle one, the second one suffers from Downs Syndrome. She lives in a supervised living situation here in Wettingen. My oldest sister, Christa, she lives not far from here. She’s very much like my mother. She’s a difficult person. She’s one who’s kind of emotionally unstable and will very quickly take offense at something you say that she interprets in a certain way. She’ll start attacking you back. Most of her boyfriend relationships have been characterized by a lot of fighting.

That’s kind of how I see my mother now from this point in life. She was a difficult person. If my stepfather beat her she sure knew how to get him to beat her. Nothing justifies each other but it’s kind of something that you can’t just see unidirectionally. I don’t think he really was that kind of person. He never touched me. He was always very correct, very fair. That made it difficult for me to relate with him. I saw him beating up my mother but my relationship was sort of okay. What am I supposed to feel or think? It was very confusing. He was actually a good guy but he really destroyed a lot of stuff.

My attention deficit disorder sort of abated. I was able to adapt to the Swiss school system. My antics were a bit, for a while, kind of legitimized because I was a foreigner who didn’t know how to behave. I very quickly learned the language and thought living here was just so much great fun. School was kind of cool too. It was this *Little House on the Prairie* type school with three grades in one room. The teacher was really good. He was the kind of person who had a very firm authority but in a way that was gentle. Everybody just sort of naturally did what he wanted.

**AS:** Even you?

**AT:** Yes.

**AS:** Interesting.

**AT:** In those times corporal punishment by teachers was not forbidden here. I got him once to the point where he took me out of the classroom, not in front of the other pupils, and slapped me. That’s really not the kind of teacher that he was. The teacher upstairs, it was known that he kept a hazel switch in the corner which he liberally used on students. That was the 60s. That was when we lived in the Zurich region. A few years after I had completed grade school we moved into Wettingen, here, which is a different canton and has a different school system. I was able to from the so-called second fahrschule, the sort of midlevel middle school in Zurich which actually is a little bit higher than the secondary school here, at that time was at least, and moved into the mittelschule which was the upper tier.

**AS:** When you were talking about how kids could move up earlier that’s what you meant.

**AT:** I was a whiz in things like, I picked up things easily.  I never had an easy time doing homework. I was horrible. I would always find excuses not to have done my homework. In classroom I could pick up things really easy. Languages and math. I was really good at math. The teacher was impressed. I was able to move along without much effort which isn’t the best attitude academically because even if you can learn things easily you should do some work and apply yourself and study stuff. I didn’t. I was able to weasel my way through. I made it into the canton schule, the one that ends with an equivalent of a baccalaureate. They have three divisions, a natural science division, and a modern language division and one of the classic languages. We had to do Latin or Greek or stuff like that. I did the natural sciences division because that’s something that I found easy. I was able to complete that school.

During the first year of that school I actually went to America and visited my biological father there. I was sixteen. I complained, “Oh God it’s so awful.” I hated living with my parents here. He offered that I could stay with him. I did, which backfired completely because from the Swiss school that I had been in, which was kind of easy going, students were allowed to smoke in recesses and stuff like that. He put me into this college preparatory school, Blake. I was supposed to wear a tie in the morning. I was just so alienated by that. I just sort of mentally left the whole scene. I went to school every day but I was just sort of sitting there. After eight months…

**AS:** You didn’t fit in socially?

**AT:** I didn’t fit in socially. None of the students lived nearby where I was living anyways. Everyone was driven there or drove there themselves from various parts. Most of them were from Edina or something like that. We were living in Kenwood. I barely had any social contacts.

**AS:** And you got plopped down when those kids had been together for years.

**AT:** Yes. I was able to speak English as a local. Nobody realized that I had a reason to have a hard time adjusting or anything like that. It was expected that I was able to do all this stuff which I was confused by and alienated by. After eight months I should have talked with my father about it but was somehow unable to at that age and stage. I ran away. I was able to scrounge up the money to get a Greyhound bus to Chicago. In Chicago I hitchhiked out to Deerport and presented a sob story to the Swiss people there. That I’d been stranded in America. They put me on a plane. They could confirm that I actually had parents there. They put me on a plane back to Switzerland.

**AS:** Who paid for the ticket?

**AT:** My mother and stepfather eventually.

**AS:** You didn’t even say goodbye to your father?

**AT**: I did later.

**AS:** Were you getting along with him?

**AT:** Yes, I was but I just felt so lost and misunderstood.

**AS:** He had other children?

**AT:** I actually felt that this was my personal failure. I had asked to stay with him and now I was failing him and not fulfilling his expectations or anything like that. It felt awful.

**AS:** Had he remarried?

**AT:** Yes, and already had Karl, my brother, and Jeff. John I’m not sure. No I don’t think he was born yet. Back in Switzerland I dived into the 1970s psychedelic hippie stuff. I dove. I consumed a lot of cannabis and LSD and stuff like that. The whole psychedelic thing. I don’t think I ever overdid it.

**AS:** Were you living at home then?

**AT:** I was living at home which I did for another year and a half. When I was nineteen a buddy and I were able to rent an old dilapidated farm house a short way from here that had cold water and an outhouse out back for like a hundred buck a month. That was affordable. I said, “Bye Mom” and just moved out. I moved together with him and completed my school from there. I took a year off and worked on construction. I travelled some, rode my motorcycle a lot. I had a big old beautiful 1951 BMW. I rode all over Europe. Around Italy and Sardinia and places like that.

**AS:** By yourself?

**AT:** By myself or with someone. I always have had kind of a tendency to travel on my own. I grew up as a single kid essentially even though I have a lot of half-brothers and half-sisters. I never felt like I was really brothers and sisters with them. They were age wise so far apart. I was the only link between my biological father and my biological mother. I almost kind of saw myself as a single kid. I knew how to be alone. Travelling alone, I have travelled with other people before. If nobody is available wanting to do the same thing I just go by myself. You always meet people along the way.

**AS:** Is that when you went to Bangkok?

**AT:** When did I go to Bangkok? No, I’d already started medical school. I did a lot of travelling. A year after I completed the local high school, the gymnasium, I went to medical school together with the guy I was living with, Chris. He later became an anesthesiologist. It was a great time. Medical school was fun. I extended it by a year because I didn’t want to get stressed out in having to complete it in just six years. I took a lot of time off in between to travel. That is the time I went to Southeast Asia.

Once I spent three months hitchhiking through the United States. I did that twice and then went down to Central America and to Mexico and stuff like that. I really enjoyed travelling. It was so cool to meet all these different people along the way. People would be interested in where you’re from and I’d get invited to stuff. It was really, really cool. In a nutshell that’s kind of how things went. I graduated from medical school in 1980. The year that I became twenty-eight. My mother died when I was twenty-three. She had breast cancer. Just after I graduated from medical school my stepfather died from lung cancer. He was a heavy smoker.

**AS:** You had younger sisters. Were they on their own already?

**AT:** No. After the death of my mother my stepfather remarried with the nanny that had looked after my half-sister while my mother was still in the hospital before she died. A weird thing. She had two further children by him, a boy and a girl. She was stuck with five children after he died. I wasn’t part of that though.

**AS:** That was not your circus. Can you talk about how you got into addiction medicine? Not addiction medicine, psychiatry.

**AT:** I stumbled into it. I’ve always been interested, even in medical school I’d pick up some kind of weird book on psychology or some kind of life view approach thing or something. Primal scream therapy or whatever. I didn’t really get in touch with psychiatry. I never saw myself as a psychiatrist. I thought it was interesting but I never saw myself as such because I thought I was too deranged and disturbed myself. These guys who were into psychiatry, we had all of these fantastic ways of speaking and explaining stuff. I’d never be able to do that.

**AS:** Your classmates?

**AT:** Classmates or older people. People would say something analytical and I’d be like, “Wow, I never would have thought of that. How do they know that?” After graduating from medical school I was kind of disenchanted with medicine all together. It’d been seven years. The final exams were a very lengthy thing. These were eighteen or twenty individual exams drawn out over a half a year. Specialty, oral, written, stuff like that. I was kind of fed up with it. After graduating I decided I’d do something else for a while. I worked at the post office. I worked at a refrigerator repair place, which was fun. I had my own little van with refrigerator repair parts. I’d go to people’s house.

**AS:** Someone trained you to do that?

**AT:** They did at the factory. They showed me how all the refrigerators worked and how to diagnose what’s wrong with them.

**AS:** You do pick things up quickly.

**AT:** For a couple months I also worked at a truck mechanics place. It was a way to earn money. That was the year I got enough money together not only to pay for my motorcycle but I wanted to do an extensive backpacking trip to the Caribbean. I was kind of looking for somebody to take of my apartment and my cats while I was gone. That was when I met Susan.

**AS:** Did she take care of the cats or did she go on the trip?

**AT:** We very quickly became enamored. She has just come over here and was glad to have a place to stay. I was going to be gone for a couple months. She took care of my apartment and fed my cats. I went to the Caribbean where I started missing her a lot. Two and a half weeks into the trip in Antigua I met a veterinarian from the United States who was there for some government project to look at the cows or something. We got drunk together and he had a motorcycle and wasn’t able to start it. I could see that it was flooded. I kicked the carburetor and adjusted it and started it for him. “Okay. I’m going over to the other bar there. You want to come along?” Along the way we wiped out and spilled. He had some lacerations, I just had some contusions. Nothing serious happened. It kind of was a jolt. Here I was in what they call the hospital in Antigua and he was getting sewed up and I was kind of sitting there really drunk. Shortly thereafter I decided this is not the way I envisioned this trip. So I booked a flight to Minneapolis, spent a week with my parents and almost every day on the phone with Susan. Then a flight back to Switzerland. Six months later we got married.

After I returned to Switzerland, that was 1981, I was able to secure a job at the medical examiner’s in Zurich where I had worked as a student previously for a couple of months and where I first got into contact with death by intravenous drug abuse. I started writing my doctoral dissertation on that which I completed after I started working there in 1982. In 1980, 1981 was the year I took off and 1982 we got married. That’s where I got really involved in addiction. I started getting really interested especially in opiate dependency. After a year and a half of that I went and I was kind of looking for jobs that had a manageable workload where I didn’t have to stay up a lot at night. I just couldn’t handle that very well. I went to work for about a year and a half at an orthopedic rehabilitation clinic. I had people who came there sort of electively. You had to manage their rehabilitation and stuff. You’d go home at night even if you had on-call duty you could just sleep there. It was kind of a cushy job, well paid. Residents generally got well paid here in Switzerland. A common starting salary after graduating as a resident would be sixty or seventy thousand dollars a year.

My original wish was I wanted to be a general practitioner. I applied for a residency and got one in Hennepin County Medical Center. We moved over there thinking I was going to do a complete residency in family medicine, family practice. That first year I was there was just horrible. I had to work one hundred and ten, one hundred and twenty hours a week, seven days a week. Every third or fourth night was just working through and continue working the next day. I got really depressed. It was almost a reenactment of when I was sixteen and had gone to visit my father. It was like after about eight or nine months I just threw in the towel and said, “Screw it.” We packed up our stuff and moved back to Switzerland. I felt horrible again because I felt like I’d disappointed my father. He was so glad that I’d come there. It was kind of hard to overcome.

I immediately got a position back at the rehab clinic where I had worked. I just was trying to figure out what I wanted to do. I decided to get into psychiatry. I got a residency job at the state mental institution. I immediately liked it. I was immediately liked by patients and personnel alike. I remember that I always wondering, “Why don’t the other doctors get involved more with the patients?” I was spending time in the wards, talking with people.

**AS:** You were?

**AT:** Yes, and the other doctors would come by once or twice a week and make their rounds and otherwise just ask the nurses what was going on. I kind of got stuck there. I thrived and was doing well, was being paid well. I had manageable hours. Sometimes I’d have to be on call but it was exceptional. That was actually at a time when a law was passed in Switzerland that even medical residents were not allowed to work more than sixty-five hours a week.

**AS:** That was in the 80s.

**AT:** After America a sixty-hour week seemed like nothing. I did that and I worked in various university clinics. I spent a year in Basel and a couple years in the outpatient services here nearby. Then I opened my own practice in 1993. That’s how I got into psychiatry.

**AS:** What happened with the addiction medicine interest?

**AT:** It was always kind of a special interest area of mine. I had lots of methadone patients when I opened my practice.

**AS**: In ‘93?

**AT:** Yes. That was when methadone was still the substitution medicine.

**AS:** When was the Needle Park? Is that ‘90?

**AT:** That started at the very end of the 80s and blossomed in the beginning of the 90s and was there for a few years. After I opened my practice it was still a thing. I think in ‘94 or ‘95 it had already been cleaned. It moved first from one place to the other.

**AS:** From the park to the station.

**AT**: It moved from Platzspitz to the Letten which was even more horrific than at the first place. Then they clamped down on it and wiped it out. Police all over the place in areas where it could reoccur, preventing scenes like that from re-sprouting.

**AS:** Were they arresting people at that point? What they doing with people?

**AT**: No. How can you arrest a thousand people in one day because they’re using heroin?

**AS:** There was never the criminal, the immediate…

**AT:** Of course there was a criminal element.

**AS:** To arrest people, was that mostly for dealers?

**AT:** Of course, but how do you make the distinction? Everybody who gets involved in heroin at some point becomes a dealer because they have to deal their own stuff. Of course there are people who are more focused on distributing. The Albanians had a reputation for doing that. It was often somebody connected with some group or criminal organization. Somebody would buy it in a great quantity from somebody and then they’d distribute it in smaller quantities to somebody else and they’d distribute it to the individual people on the scene. Then they would redistribute it and so on. Where do you make the line?

**AS:** Who to arrest?

**AT:** Where is the victim and where is the perpetrator? Where’s the difference? It’s almost a continuum. Some people were arrested just because they were carrying something with them. They were seldom persecuted. Some people were persecuted. Some people I’m not sure whether it was sensible to be persecuted. A friend of mine who was a dentist, he spent two years in a regional penitentiary because he was caught with cocaine and he was selling it. He was a dentist. He was making good money off of his profession. It’s not like he needed to become rich by selling cocaine. It was more something he was just involved in because he was consuming heavily himself. They put him away. Other people I know died.

**AS:** During that time?

**AT:** Yes.

**AS:** Friends?

**AT:** People I knew. Fortunately, none of my closer friends. Maybe the dentist has died since. I don’t think it’s drug related. As Thilo Beck says, his lifestyle. Last time I saw him he was obese and looked pasty and unhealthy.

**AS**: Do you remember what your dissertation was about? What made it unique in the time that you wrote it?

**AT:** The time that I started writing it heroin addiction was just starting to bloom. The title of the dissertation was, “The Exceptional Deaths.” A term for a medical examiner, somebody who doesn’t die of natural causes. A death that is unexplainable, unnatural, or extraordinary death. Literal translation is extraordinary death. Of intravenous drug abusers, a canonistic study of one hundred cases. Most of those hundred cases occurred in 1979 and 1980. It was like a flat curve and then it went up like that.

**AS:** Just like we’re starting to see.

**AT:** During the 80s the heroin abuse climbed and climbed and climbed. Where previously a couple of people had died per year from it, it was dozens in small Switzerland. Or over one hundred per year. Then at the end of the 80s like Beck said, the most intense drug scenes in the world happened in the middle of Zurich. People pouring in from Germany, from France just to come there to get drugs.

**AS:** Do you know where the heroin was coming from?

**AT:** Mostly from Afghanistan I believe.

**AS:** Were they able to curb the…

**AT:** Some from Morocco probably also.

**AS:** When the introduction of the methadone therapy happened, was there also a simultaneous bust of the heroin market? Do you know how that kind of worked out? Was there a police effort towards getting rid of it?

**AT:** Yes, there was.

**AS:** Did those things happen simultaneously?

**AT:** Yes. It very quickly became evident that it’s useless to pursue the users. You have to find out who the distributors are, the dealers. The police efforts were concentrated on that. A lot of people got caught up in the net but the focus was where is it coming from and how do we cut this off?

**AS:** Were they or weren’t they working in conjunction with each other? Was the impulse towards the care for the addicts, getting people off the street, did that happen separately or were they cooperating at all?

**AT:** As I remember it, it was separately but there were attempts with communication and cooperation. Politically at that time, it was so open and so visible and so in everybody’s faces. It could not be ignored. It could not be denied. It was there. It was part of our society. Almost everybody knew a family whose kid had got caught up in that. It was just devastating. Society had to deal with it. They came to this understanding; we can’t just deal with it by repressing it. We have to also do prevention. We have to do treatment. The four pillars that we say, I can’t think of what they are exactly. It’s a more differentiated approach and not just forbidding it. You can’t forbid something, prohibit something that so many people are doing anyways regardless of it being prohibited. It’s not going to go away just by outlawing it. A more permissive attitude sort of came forth then. They started leaving this expectation that people who were on drugs were just going to stop using them and become abstinence and be detoxed and then be okay. It hardly ever works that way. Occasionally somebody does and that’s good. Mostly not.

**AS:** You opened your own practice, how did patients who had opiate issues find you? Are all psychiatrists prepared to deal with opiate addicts? I’m just trying to understand your medical system. We would say you’re an addiction medicine doctor or you’re just a psychiatrist. Those two in the U.S. don’t often overlap in private practice.

**AT:** I’d say generally psychiatrists don’t want to or need to treat people with this kind of addiction. Oftentimes because it’s viewed as something very strenuous you’re going to wind up with your bills not getting paid, stuff like that. The patients are going to be lying to you all the time. This also stems from the attitude, “I’m the doctor. I’m going to counsel you on what you need to do to overcome your problems.” Especially in addiction you can’t do that. You have to find out where that person is at that moment and take it from there. You can’t superimpose this expectation of yours which doesn’t fit the frame of reference of the patient. You have to very carefully feel out the frame of reference of this person. Including his substance abuse or her substance abuse and where they’re standing and why they have come to you. What they actually want from you. Without saying, “This is what I want from you. This is what you have to do.” They’re coming to you with an expectation that you’re going to help them in a certain way. You have to find out what that is. It might not be realistic but it usually is not realistic in a way that they are expecting me to do much more for them. Ultimately them achieving much more than they are actually able to do at that moment.

Oftentimes my first job is to just find out where they are, give them the feeling that they’re being listened to and understood, and then start toning down their expectations. “Listen. You can’t just stop taking that. You can’t just detox and everything will be okay. Let’s try methadone or Dolophine or oral morphine, the slow release type. You have to be open to various options and approaches.” Oftentimes you need to accept the fact that in the background they’re using other substances. Each case is its own individual case. Of course there are certain patterns that the addict does this and that. It’s very personal.

**AS:** Has your practice always been that way? Do you think that the time you spent working at the hospital, the state hospital where you spent more time with patients, do you feel like that influenced your attitude towards addiction and towards people who were struggling with addiction?

**AT:** I started to. It’s been a long road. I’ve been in this business now for almost thirty years.

**AS:** Maybe you could talk about how it’s changed?

**AT:** It has a lot to do with my own personal experience too. A lot of personal stuff and realizing how vulnerable I am. This is not something that is just a bad life choice. This is something that can happen to you. I mentioned in one of the letters that I had my own brush with morphine. This is something that took me completely by surprise. This was shortly before I opened my practice. My friend, the anesthesiologist, had just gotten some practice permit. He said, “Let’s see what this whole thing is about this flash.”

**AS:** Flash?

**AT:** The flash, the rush, when you inject an opiate. He had morphine ampules and we shot intravenously ten milligrams. It was at first, “This is kind of relaxing and nice.” But actually a little bit too much because I kind of was woozy and drowsy. I tried it again but with only five milligrams, a very small amount comparatively. That was, “Oh my God.” All my troubles with attention deficit disorder, my problems with concentration, my problems with the strenuous—with keeping up a conversation with anybody and staying focused on the subject and not drifting away mentally and my ability to read and retain stuff was just better. I went to twice a week. It was helpful.

It was that point where I started feeling discouraged and craving. I got addicted. I detoxed three or four times. If you’re taking something you’ve just really got to stay away from it because then my disdain for being dependent on something like that and my willingness to compromise. I’m clean but I’d still call myself an addict. I have vast amounts of oral morphine in my practice because I have to distribute it. I never ever, ever keep injectable morphine in my practice. I know that it’s too tempting. I could go buy it any time from the pharmacy.

**AS:** Because you’re a doctor.

**AT**: But I don’t do that. It’s just I know I cannot fool myself into thinking, once it will be okay. They come in packs of ten and I won’t be able to not use up the entire pack of ten. You can also buy them in boxes of one hundred ampules. They have ten milligram and twenty milligram ampules. It’s a really easy split. I just keep it at a distance.

**AS:** If someone needs that they can go somewhere else.

**AT:** This was a very, very profoundly humiliating experience.

**AS:** How so?

**AT:** I never thought that could happen to me. It never did with any other substance. I can smoke a joint tomorrow and then not think about it for a year. I like a glass of wine but I don’t crave it. I could easily go days or weeks without it. I had cocaine, I didn’t like the effect because it made me all tight and nervous and crabby. I talked a mile a minute but I didn’t like the way I was physically feeling when I was on it. I avoid it.

**AS:** How long did that last for you? Did you take it like three or four times?

**AT:** Altogether like ten years.

**AS:** Ten years? How did that go over in your family life?

**AT:** Not well. Susan started to notice. She could tell that I was using. Sometimes she thought I was using and wasn’t. She was never sure. I lied about it or denied it or denied it when I actually wasn’t doing but she didn’t believe me. Stuff like that. It was a difficult thing. Like Thilo Beck said, I’m a doctor. I can buy the clean stuff and inject it cleanly. I might have injected two or three thousand times but you can’t see anything on my veins.

**AS:** Because you’re a doctor?

**AT:** I’m a doctor. I know how to do it. I know I need to stay away from that.

**AS:** Did you use methadone?

**AT**: No, I never wanted that stuff. I just stopped.

**AS**: But it took you a few times?

**AT:** Yes. I’d be using it for two weeks and working and performing just fine. Once or twice one of my addict patients suspected me because they just knew.

**AS:** And said that to you?

**AT**: I talked my way out of it. “I’m so kaput today because I didn’t sleep last night.” Or something like that. Then I was off of it and clean. They weren’t sure anymore.

**AS:** What was the humiliating part?

**AT**: I was not in control. I was actually being controlled by the substance.

**AS:** You have a deeper understanding now?

**AT:** I know how powerful that can be.

**AS:** When you talk about a personal connection.

**AT:** I know how you can be thinking rationally and you’ll be doing something completely contrary. Knowing as I’m doing it that I don’t want to do it but I’m doing it anyways. Here it is. “Oh my God that feels good. Why did I do that? What an asshole now I did it again.”

**AS:** That consciousness is always there.

**AT:** The other part is like somebody else is holding the steering wheel and driving you. It’s a profound thing and I think it’s kind of unique for the opiates. They have such an intricate way of interacting with the receptors in your brain and so specific in the way they interact with your brain. They quickly are after a relatively short time can change the way that your brain is functioning and the way of steering your thoughts and your behavior.

**AS**: Do you feel like you got that back?

**AT:** Yes, but I am very respectful of it. I will never have that in my practice or close to me because I couldn’t resist.

**AS:** What about your friend the anesthesiologist?

**AT**: He didn’t get into that. Maybe he was less vulnerable than me. Maybe he never had attention deficit disorder or something like that. I never identified with my patients. I started to understand them better but I never felt, “You’re the same as me.” It’s not like I chummed up to them.

**AS:** You understood more about what they were going through. You had not previously had an experience where you couldn’t control—

**AT:** I was pretty understanding before but you can’t really know what it is. It’s not something that you should have to know. You shouldn’t have to have that experience. The price is just way too high. In that sense it’s very humiliating. I never feel ever even this much superiority over my patients. I know why they lie. I know that works. I know how much they hate themselves for lying. The whole shame thing and everything is just mind blowing.

**AS:** That’s powerful. What I wanted to ask is what’s changed in your practice besides you? What changes have you seen? Beck was talking about the substantial decrease of the numbers and the increase in age because heroin’s not in. How has your practice changed? What have you noticed around opioids?

**AT:** Hard to say what has changed around me or what I have changed myself. I used to work a lot more, see patients five or five and a half days a week. I was insane. A few years back really started to realize how morphine was helping me to work more.

**AS:** How long ago did you stop?

**AT:** A couple years was the last time I used it. There were gaps.

**AS:** But it was over a period of ten.

**AT:** I was very worried about myself.

**AS:** What made you not take methadone?

**AT:** I took methadone or oral morphine just to bridge over a certain gap of time before I knew I could take two or three weeks off to detox.

**AS:** You know what you’re doing. Take two or three weeks off of work to detox because that’s how long it would take?

**AT:** It would take me four or five days to get over the worst but then you’re shaking depending on how long you’ve used. You’re going to have post-acute withdrawal symptoms for up to a year or two.

**AS:** Those are serious. Back to your patients. How did it change?

**AT:** I reduced the number of addict patients I treat. Most of the patients that are being treated by me I’ve been treating for years. I haven’t taken on many new ones.

**AS:** Just addict patients?

**AT:** Beck mentioned, I can confirm that. Most people I see are…

**AS:** In their forties or fifties.

**AT:** I can’t remember the last time I’ve seen a teenaged user.

**AS:** But when you started your practice?

**AT:** I had sixteen, seventeen year olds. My youngest patients were sixteen and already heavy heroin users. It was a long battle on methadone and this and that. There’s still cocaine there. What are we going to do? We’ll prescribe methylphenidate, Ritalin.

**AS:** Does that help with cocaine addiction?

**AT:** Sort of. It’s a stimulant. It’s not like they’d totally not crave it. In some way or another it helps them maintain a certain stability. I’ll go along with it. As long as it works it works. The pragmatic approach. It’s a difficult thing when you treat addicts. It’s not a quick thing. You’re in for a long haul always.

**AS:** Your medical model is set up to accommodate that?

**AT:** To a degree. I work together with pharmacies. I work with federal practitioners. I actually am one of the very, very few, I don’t know another psychiatrist except for Arud in Zurich which is a huge practice there, I take blood and there’s a central lab in Baden that I bring it over to and do lab work there. I do maintain a very, very small amount of physical contact with my patients. I measure their blood pressure or listen to their heart. Where was I going?

**AS:** We were talking about your patients, the age of your patients and how its changed.

**AT:** It’s rare that I get somebody below twenty for anything anymore which is okay. I’m older myself. I think it might have to do with the fact that when I started my practice I was much younger and probably projected a much more dynamic, youngish me which younger patients could identify with more.

**AS:** How are people referred to you in private practice?

**AT:** I’d say about a fifth of them just hear about me and call me up. The rest, half of the rest get referred by practitioners and the other half by the psychiatric institute. Most of my patients are not addicts.

**AS:** It seemed like you said this earlier, did you purposely reduce the number of addict patients or have they naturally declined?

**AT:** It’s hard to say. I purposely sort of withdrew a little bit from that because it’s really taxing. In private practice if you don’t have an infrastructure and a lot of personnel and social workers and stuff like that to help additionally it’s a lot of work.

**AS:** Because of the lifestyle that Beck was talking about.

**AT:** The different aspects.

**AS:** All the stigma and the problems.

**AT:** Their whole living situation, who they’re living with, their economic situation, their job. All this stuff. How are they buying food? Who’s paying for it? Where’s it coming from? Do they have social services of the municipality there to help them?

**AS:** When you take on an addict patient you’re taking on all that.

**AT:** The whole thing. All that. Which I don’t do myself but I have to be in phone contact with the social services of the municipality or their primary care physician or with their employer or with their landlord or whatever.

**AS:** That stuff typically doesn’t happen with your other patients.

**AT:** Not as much. It’s a lot of work and a lot of work that I can’t charge for.

**AS:** Because it’s not the one on one time.

**AT:** I have a petition for work in absence of the patient but you can’t overdo it. The insurance will just refuse to pay it.

**AS:** I have a question here about best practices for the future of addiction treatment. If you could predict something that would happen regarding addiction treatment what would it be? If you could change something for the better in the current system here? Best practices, something that will happen or that you see coming up ahead or something that you could change.

**AT:** I think education of health professionals needs to start early and with a bigger emphasis on it. It’s a huge part of our society, of the health system, of what we have to deal with, it’s underrepresented.

**AS:** And underfunded.

**AT:** Yes. The whole understanding of addiction, like tobacco addiction is completely under dealt with. It’s addiction that’s about as bad as heroin addiction. People who are hooked on cigarettes have a hard time stopping.

**AS:** There’s not much here for that.

**AT:** They talk about the amount of deaths from heroin, there’s ten times as much death from tobacco.

**AS:** Still today. That’s a good point.

**AT:** It’s legal. You can buy it every place. You go outside and smoke. Alcohol is more noticed but still that’s very accepted. It takes a long time for acquaintances or relatives of an addict to admit that the one close to them is having a problem with alcohol. It will be overlooked and denied and sort of rationalized. Then for the person who is consuming it themselves, they accept that themselves because it’s part of society. Almost everybody drinks. Ninety-five percent of the drinkers can handle that and five percent consume seventy-five percent of what’s consumed.

**AS:** Here?

**AT:** I think that’s probably universal.

**AS:** Five percent consume seventy-five percent. More education.

**AT:** More education, more knowledge about it, more understanding, and you need a lot of experience.

**AS:** Would you say even by education it’s just with health professionals? How is your school system? Does your school system here offer drugs education?

**AT:** More than they used to but I’m not sure how useful that is because the educational system is dealing with kids. There’s a degree you can educate them about addiction and substances and stuff like that. It’s something that, “Okay I see my parents drinking wine. I’m not exactly sure what you’re talking about.”

**AS:** More medical professionals.

**AT:** I think in higher levels of public education you could probably introduce this topic. For teenagers, make them aware that this is something that you have to be aware of and careful of. They need to know some facts about drugs that can easily become available at a party or on the street, heroin or cocaine, before they try it. So that they have an idea of what they might be risking and getting into just by touching the stuff.

**AS:** Would you talk a little bit about, you were talking the other day about why you’re not in favor of legalization of everything.

**AT**: I’m just not sure.

**AS:** Is marijuana legal here?

**AT:** No. It should be more legal. When I talk about legalization often people think about it as this black and white thing. Tobacco is regulated legally, so is alcohol. There’re rules and you can get in trouble.

**AS:** They have different rules.

**AT:** It’s a question of how we regulate it legally not whether it’s just illegal or legal. I think you have to take into account the different risks of these different substances. Opiates is kind of in a way different from the other things. Cocaine is different but it also has similarities with other stimulants and stuff. Opiates are very distinct idiosyncratic effect. Alcohol is just a cell poison. You bathe yourself in it and they sort go “Ugh” and release their dopamine. Opiate, that docks onto a very specific point and tricks the nerves into thinking something else.

**AS:** It’s very quickly lethal if you use too much of it.

**AT:** If you use too much of it you’ll stop breathing.

**AS:** Anything else?

**AT:** Not that I can think of at the moment. I’ve been babbling away.

**AS:** What about the future? Is there something if you could offer some idea for public policy or something for the future? Maybe it’s education as you already said but is there any other care or treatment for people?

**AT:** Make it available I think. Public acceptance that this is an aspect that should not be so stigmatized that needs to be accepted as something that you can become addicted just the same way as you can suffer from high blood pressure. If you have high blood pressure you always have to take a medication that keeps it in the low range. Countless other, like diabetes. Okay there might be some different ways of looking at it and understanding it but in certain aspects why should you think of it differently? It’s a health problem.

**AS:** It’s what Beck was talking about earlier today. It’s the way that it’s stigmatized that marginalizes the people that do have a problem. Their life becomes complex and difficult because of their marginalization, because of the stigma. Right?

**AT:** The only thing that makes heroin so dangerous is it enters your brain about ten times more easily than morphine. If you inject it this huge wall of heroin is immediately entering your brain. The sharp rise in the concentration might be a temporal overdose. Your brain doesn’t have enough time to adjust to this amount of effect. Your breathing just shuts down, your heart stops. That’s an overdose. Apart from that it’s not particularly dangerous. If you take an amount of heroin that you can tolerate your health isn’t going to be impaired. You’re just going to be dependent on it.

**AS:** That can turn out to be a problem.

**AT:** It can be a problem. I like being able to move freely. I want to go to the states for a few weeks and not have to worry about having something with me that maintains me. These are the motivational factors that Beck was talking about. I have lots of reasons that I don’t want to.

**AS:** With the motivational thinking or interviewing. Those are powerful. I think my son-in-law had a counselor who used that. I remember he was talking about that he really liked it. He liked a therapist using that model.

**AT:** The whole politics towards this needs to change. It’s just so tiresome because there are experts who have a lot of knowledge and experience about it but their hands are tied by the greater way that it’s being seen by society and by the health department and by the politics.

**AS:** And the different administrations that come in and the ruling parties and how quickly you can backtrack and lose ground on something.

**AT:** How flexible are you as a therapist? How flexible can you use substitution agents or other treatment modalities that you can offer? Talk therapy, group therapy, institutionalization, whatever works or is desired or is acceptable or makes sense. This whole thing about, “You have to not take it and you’re only a wonderful person if you’re not addicted or dependent on anything at all.” It doesn’t work that way, it can’t. You can argue, “You made a bad decision.” It’s not like that. You have peer pressure; you have all sorts of things coming into play. You have a teenager who’s heard all this stuff and they think, “Yeah, yeah that’s what all the adults are saying. Here my friend is offering me something and he’s taking it. He looks okay. I’m going to see what it’s like myself.” You can’t just say this is a bad decision. It’s the way things go.

**AS:** We need to create supports for someone to pull back from it that are consistent and non-judgmental.

**AT:** Yes. This needs to be very readily available.

**AS:** To catch it.

**AT:** And easily available. Somebody at ten o’clock in the morning could be like, “God I can’t continue this way.” And at one in the afternoon walks into a place like Arud it’s good that something happens right then.

**AS:** Thank you.

**AT:** Sure.

**AS:** [Speaking to cat]. Thanks kitty.

[End of Recording]