Subox.Info

Is Suboxone At Odds With Traditional Recovery?

Jeffrey T Junig MD PhD

By now almost every opiate addict has heard of suboxone, the amazing medication for opiate dependence that has taken the using world by storm. I will admit to mixed feelings about suboxone based on what I have seen and heard while treating well over 100 patients over the past two years. I also acknowledge that my opinions are likely influenced by my own experiences as an addict in traditional recovery. While suboxone has opened a new frontier of treatment for opiate addiction, it also threatens to split the recovering and treatment communities along opposing battle lines. Such and outcome would be a huge missed opportunity to improve the lives of opiate addicts.

An amazing medication.

For clarification, the active ingredient in Suboxone is buprenorphine, a partial agonist at the mu opiate receptor. Suboxone contains naloxone to prevent intravenous use; another form of the medication, Subutex, consists of buprenorphine without naloxone. In this article I will use the name 'Suboxone' because of the common reference to the drug, but in all cases I am referring to the use and actions of buprenorphine in either form. The unique effects of buprenorphine can be attributed to the drug's unique molecular properties. First, the partial agonist effect at the receptor level results in a 'ceiling effect' to dosing after about 4 mg, so that increased dosing does not result in increased opiate effect beyond that dose. Second, the high binding affinity and partial agonist effect cause the elimination of drug cravings, dispelling the destructive obsession with use that destroys the personality of the user. Third, the high protein binding and long half-life of buprenorphine allows once per day dosing, allowing the addict to break the conditioned pattern of withdrawal (stimulus)-use (response)- relief (reward) which is the backbone of addictive behavior. Fourth, the partial agonist effect and long half life cause rapid tolerance to the drug, allowing the patient to feel 'normal' within a few days of starting treatment. Finally, the withdrawal from buprenorphine provides a disincentive to stop taking the drug, and so the drug is always there to assure the person that any attempt to get high would be futile, dispelling any lingering thoughts about using an opiate.

Different treatment approaches.

At the present time there are significant differences between the treatment approaches of those who use suboxone versus those who use a non-medicated 12-step-based approach. People who stay sober with the help of AA, NA, or CA, as well as those who treat by this

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approach tend to look down on patients taking suboxone as having an 'inferior' form of recovery, or no recovery at all. This leaves suboxone patients to go to Narcotics Anonymous and hide their use of suboxone. On one hand, good boundaries include the right to keeping one's private medical information so one's self. But on the other hand, a general recovery principle is that 'secrets keep us sick', and hiding the use of suboxone is a bit at odds with the idea of 'rigorous honesty'. People new to recovery also struggle with low self esteem before they learn to overcome the shame society places on 'drug addicts'; they are not in a good position to deal with even more shame coming from other addicts themselves!

An ideal program will combine the benefits of 12-step programs with the benefits of the use of suboxone. The time for such an approach is at hand, as it is likely that more and more medications will be brought forward for treatment of addiction now that suboxone has proved profitable. If we already had excellent treatments for opiate addiction there would be less need for the two treatment approaches to learn to live with each other. But the sad fact is that opiate addiction remains stubbornly difficult to treat by traditional methods. Success rates for long-term sobriety are lower for opiates than for other substances. This may be because the 'high' from opiate use is different from the effects of other substances—users of cocaine, methamphetamine, and alcohol take the substances to feel up, loose, or energetic—ready to go out and take on the town. The 'high' of opiate use feels content and 'normal'— users feel at home, as if they are getting back a part of themselves that was always missing. The experience of using rapidly becomes a part of who the person IS, rather than something the patient DOES. The term 'denial' fits nobody better than the active opiate user, particularly when seen as the mnemonic: Don't Even Notice I Am Lying.

The challenges for practitioners lie at the juncture between traditional recovery and the use of medication, in finding ways to bring the recovering community together to use all available tools in the struggle against active opiate addiction.

Drug obsession and character defects.

Suboxone has given us a new paradigm for treatment which I refer to as the 'remission model'. This model takes into account that addiction is a dynamic process— far more dynamic than previously assumed. To explain, the traditional view from recovery circles

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is that the addict has a number of character defects that were either present before the addiction started, or that grew out of addictive behavior over time. Opiate addicts have a number of such 'defects.' The dishonesty that occurs during active opiate addiction, for example, far surpasses similar defects from other substances, in my opinion. Other defects are common to all substance users; the addict represses awareness of his/her trapped condition and creates an artificial 'self' that comes off as cocky and self-assured, when deep inside the addict is frightened and lonely. The obsession with using takes more and more energy and time, pushing aside interests in family, self-care, and career. The addict becomes more and more self-centered, and the opiate addict often becomes very 'somatic', convinced that every uncomfortable feeling is an unbearable component of withdrawal. The opiate addict becomes obsessed with comfort, avoiding activities that cause one to perspire or exert one's self. The active addict learns to blame others for his/her own misery, and eventually their irritability results in loss of jobs and relationships.

The traditional view holds that these character defects do not simply go away when the addict stops using. People in AA know that simply remaining sober will cause a 'dry drunk'—a nondrinker with all of the alcoholic character defects-- when there is no active recovery program in place. I had such an expectation when I first began treating opiate addicts with suboxone—that without involvement in a 12-step group the person would remain just as miserable and dishonest as the active user. I realize now that I was making the assumption that character defects were relatively static—that they developed slowly over time, and so could only be removed through a great deal of time and hard work. The most surprising part of my experience in treating people with suboxone has been that the defects in fact are not 'static', but rather they are quite dynamic. I have come to believe that the difference between suboxone treatment and a patient in a 'dry drunk' is that the suboxone-treated patient has been freed from the obsession to use. A patient in a 'dry drunk' is not drinking, but in the absence of a recovery program they continue to suffer the conscious and unconscious obsession with drinking. People in AA will often say that it isn't the alcohol that is the problem; it is the 'ism' that causes the damage. Such is the case with opiates as well—the opiate is not the issue, but rather it is the obsession with opiates that causes the misery and despair. With this in mind, I now view character defects as features that develop in response to the obsession to use a substance. When the

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obsession is removed the character defects will go way, whether slowly, through working the 12 steps, or rapidly, by the remission of addiction with suboxone.
In traditional step-based treatment the addict is in a constant battle with the obsession to use. Some addicts will have rapid relief from their obsession when they suddenly experience a 'shift of thinking' that allows them to see their powerlessness with their drug of choice. For other addicts the new thought requires a great deal of addition-induced misery before their mind opens in response to a 'rock bottom'. But whether fast or slow, the shift of thinking is effective because the new thought approaches addiction where it lives—in the brain's limbic system. The ineffectiveness of higher-order thinking has been proven by addicts many times over, as they make promises over pictures of their loved ones or try to summon the will power to stay clean. While these approaches almost always fail, the addict will find success in surrender and recognition of the futility of the struggle. The successful addict will view the substance with fear—a primitive emotion from the old brain. When the substance is viewed as a poison that will always lead to misery and death, the obsession to use will be lifted. Unfortunately it is man's nature to strive for power, and over time the recognition of powerlessness will fade. For that reason, addicts must continue to attend meetings where newcomers arrive with stories of misery and pain, which reinforce and remind addicts of their powerlessness.

The dynamic nature of personality.

My experiences with Suboxone have challenged my old perceptions, and led me to believe that the character defects of addiction are much more dynamic. Suboxone removes the obsession to use almost immediately. The addict does not then enter into a 'dry drunk', but instead the absence of the obsession to use allows the return of positive character traits that had been pushed aside. The elimination of negative character traits does not always require rigorous step work— in many cases the negative traits simply disappear as the obsession to use is relieved. I base this opinion on my experiences with scores of suboxone patients, and more importantly with the spouses, parents, and children of suboxone patients. I have seen multiple instances of improved communication and new-found humility. I have heard families talk about 'having dad back', and husbands talk about getting back the women they married. I sometimes miss my old days as an anesthesiologist placing labor epidurals, as the patients were so grateful—and so I am

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happy to have found Suboxone treatment, for it is one of the rare areas in psychiatry where patients quickly get better and express gratitude for their care.

A natural question is why character defects would simply disappear when the obsession to use is lifted? Why wouldn't it require a great deal of work? The answer, I believe, is because the character defects are not the natural personality state of the addict, but rather are traits that are produced by the obsession, and dynamically maintained by the obsession.

Combining suboxone treatment and traditional recovery.

Once the dynamic relationship between use obsession and character defects is understood, the proper relationship between suboxone and traditional recovery becomes clear. Should people taking suboxone attend NA or AA? Yes, if they want to. A 12-step program has much to offer an addict, or anyone for that matter. But I see little use in forced or coerced attendance at meetings. The recovery message requires a level of acceptance that comes about during desperate times, and people on suboxone do not feel desperate. In fact, people on suboxone often report that 'they feel normal for the first time in their lives'. A person in this state of mind is not going to do the difficult personal inventories of AA unless otherwise motivated by his/her own internal desire to change.

The role of 'desperation' should be addressed at this time: In traditional treatment desperation is the most important prerequisite to making progress, as it takes the desperation of being at 'rock bottom' to open the mind to see one's powerlessness. But when recovery from addiction is viewed through the remission model, the lack of desperation is a good thing, as it allows the reinstatement of the addict's own positive character. Such a view is consistent with the 'hierarchy of needs' put forward by Abraham Maslow in 1943; there can be little interest in higher order traits when one is fighting for one's life.

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Other Questions (and answers):

-Should suboxone patients be in a recovery group?
I have similar reservations about forced attendance, but there is something to be gained from the sense of support that a good group can provide.
-What is the value of the 4th through 6th steps of a 12-step program, where the addict specifically addresses his/her character defects and asks for their removal by a higher power? Are these steps critical to the resolution of character defects?
These steps are necessary for addicts in 'sober recovery', as the obsession to use will come and go to varying degrees over time depending on the individual and his/her stress level. But for a person taking suboxone I see the steps as valuable, but not essential.
-Where does methadone fit in?
Methadone is just another opiate agonist. A newly-raised dosage will prevent cravings temporarily, but as tolerance inevitably rises, cravings will return. With cravings comes the obsession to use and the associated character defects. This explains the profound difference in the subjective experiences of addicts maintained on suboxone versus methadone, and explains why in my practice I have many patients who have switched to suboxone, but none in the other direction.

The downside of suboxone.

Practitioners in traditional AODA treatment programs will see suboxone as at best a mixed blessing. Desperation is often required to open the addict's mind to change, and desperation is harder to achieve when an addict has the option to leave treatment and find a practitioner who will prescribe suboxone. Suboxone is sometimes used 'on the street' by addicts who want to take time off from addiction without committing to long term sobriety. Suboxone itself can be abused for short periods of time, until tolerance develops to the drug. Snorting suboxone reportedly results in a faster time of onset, without allowing the absorption of the naloxone that prevents intravenous use. Finally, the remission model of suboxone use implies long term use of the drug. Chronic use of any opiate, including suboxone, has the potential for negative effects on testosterone levels and sexual function, and the use of suboxone is complicated when surgery is necessary. Short- or moderate-term use of suboxone raises a host of additional questions,

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including how to convert from drug-induced remission, without desperation, to sober recovery, which often requires desperation.

The beginning of the future.

Time will tell whether or not suboxone will work with traditional recovery, or whether there will continue to be two distinct options that are in some ways at odds with each other. The good news is that treatment of opiate addiction has proven to be profitable for at least one pharmaceutical company, and such success will surely invite a great deal of research into addiction treatment. At one time we had two or three treatment options for hypertension, including a drug called reserpine that would never be used for similar indications today. Some day we will likely look back on suboxone as the beginning of new age of addiction treatment. But for now, the treatment community would be best served by recognizing each other's strengths, rather than pointing out weaknesses.

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