



## RESPONSE: THE NEUROBIOLOGICAL MODEL IN COMMUNITY TREATMENT PROGRAMS

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*Chris Farentinos:* This is very important information for patients and counselors to have. Patients can understand their reactions in terms of, ‘By taking this drug I stimulated my brain so much I’ve kind of extinguished its ability to produce certain neurotransmitters, and once I stop taking the drug, dysphoria will arise and that creates a cycle of addiction.’ And the counselor can have more empathy for the client: It’s not that the clients are not trying to get better or that they are bad people, but they feel so bad after they stop using the drug that they have to go back. There is also a neurobiological connection to impulsivity and personality disorders, so the whole thing fits together.

*Doug Ziedonis:* From a pragmatic point of view, this kind of article is useful for stigma-busting with legislatures, since they don’t want to pay for habits or choices. They want to pay only in cases of medical necessity.

The recovery community agrees with the disease concept of addiction. Most of the recovery models people use when working with addicted patients use some type of bio-psycho-social-spiritual matrix. The biological part is considered most important in early stages of recovery, maybe during the first year, because the patient has to deal with acute withdrawal, dependence, and then protracted withdrawal.

Where the recovery and medical communities often don’t see eye to eye is when the disease concept gets translated into a rationale for using medication, whether it is in the case of dual-diagnosis patients or even the use of naltrexone to treat opiate addiction. Naltrexone is a great medication; it can be very useful in treating impaired professionals. But if you survey average community treatment programs, hardly any patients are on naltrexone. Methadone is its

own medical model system that doesn’t always link well with places that use the abstinence model. I have worked at abstinence programs and have worked at Yale as medical director of a methadone program. I favor the use of methadone as part of a treatment continuum.

*Tom Brewster:* Therapeutic communities have long been the most resistant single group to the use of medications for opiate abuse treatment. I think there has been a movement among providers to utilize methadone more in our therapeutic communities. There certainly has been in my community. We actively maintain patients on the medication and have trained our counselors. Our recovering counselors are abstinence-oriented individuals: they don’t drink and they certainly aren’t using illicit substances. They generally challenge any form of medication, particularly analgesic medication, even when it should be legitimately used for pain reduction after surgery and so forth. But our program has embraced methadone despite this resistance, because of the biological connection described by Kosten and George.

The information about biology and about medications is useful for patients who are asking to be taken off methadone. Patients come to me and say, ‘I want to detox. Methadone is not good. It is a weakness. My wife wants me off of it, my employer wants me off, society wants me off, my probation officer wants me off.’ Corrections workers press patients to feel guilty about taking a narcotic medicine. They don’t believe in it. We resist this pressure because we know better. The relapse rate of those who get off methadone maintenance is perilously high. We strongly discourage people from going off the medicine. &