Withdraw to Freedom

By

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This book is not intended as a substitute for the medical advice of physicians. The reader should regularly consult a physician in matters relating to his/her health and particularly with respect to any symptoms that may require diagnosis or medical attention.

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Introduction

Withdraw to Freedom is intended as an empowering guidebook, both for those addicted to opiates currently or imminently receiving treatment, and for their loved ones. To be honest, it seems unlikely a narcotic addict in the deepest despair, pursuing an active drug habit, will spend time to sit down and read this book cover-to-cover; however, the information and guidance remain available once they're stabilized and can show interest. Hopefully, family members will have even more opportunity (and time and perspective) to use this book as both a resource and conversation-starter. *Withdraw to Freedom* provides a vantage point from which addicts, family members, and treatment professionals can meet, understand, and coordinate addiction treatment, tailoring it for the specific needs of the individual, not of the treatment clinic.

If lost and disoriented, finding a map's "*YOU ARE HERE*" icon is a relief, clarifying one's position, reorienting goals, and strategizing the best path, including the exit. But within a narcotic addict's secretive world, so much is kept from view. There are similarities even once treatment begins. *Withdraw to Freedom* intends to clarify the various pathways within this difficult treatment maze. Admittedly, it does so with a particular perspective implicit in the title: the importance of *freedom*, emphasizing hope, opportunity, growth, fulfillment, and soul. It comes from a minority viewpoint within the addictionology field. Nearly universally, long-term maintenance is encouraged over attempts to taper and withdraw to sobriety and to freedom. In contrast, *Withdraw to Freedom* advocates judicious and appropriate tapering.

Entering treatment is never easy, but sometimes less difficult than leaving it. Maintenance-styled treatment centers have mixed motivations in letting people (i.e. their customers) go; furthermore, recovering addicts can experience insecurity on the thought of leaving the comfort of a clinic, and the reassurance of a pill, behind.

Once in treatment, freedom from drugs and replacement drugs may be the last thing on an active addict's mind. Self-confidence is in short supply, whether from personality, prior events, or recent addiction havoc. A period of stabilization and reorientation is beneficial. The question (perhaps the largest question) brought up by this book is, "How long should that period be?" The timeframe for recovery of spirits from life's other emotional traumas leading to grief (the death of a parent, spouse, or child), breakups and divorce, failure (losing a job, expulsion from a

group), or arrest and incarceration, is on the order of four to six months.[1] Humans are not robots, so "results may vary." People retain longer the wistful nostalgia of loss, but within months are often ready to pick up, start over, and meet new challenges.

You've probably heard this alluring and seemingly sensible phrase repeated as mantra, *"If we can save only one life, then it will have all been worth it!"* [2] Of course, there are competing philosophies regarding saving lives. At the extreme, for instance, if all of society stayed completely locked-down for the next twenty years, perhaps there would be zero lives lost to infectious illnesses (like coronavirus); but if we did so, we might very well starve societally and decay from a lack of commerce and industry, or individually drink ourselves into a stupor from boredom. The point is that of course there are trade-offs. Overly aggressive attempts to eliminate all possibilities of danger, by unintentionally limiting individuals' challenges, limit the quality of life broadly and often fail even in the specified goal of "saving one life" by sacrificing the lives of others.

Medical doctors abide by the Latin expression, "*Primum non nocere"*[3] ("First, do no harm"). A practicing physician, however, can never make a blanket promise that there will never be any harm. Even an aspirin has potential side effects, as does every other type of treatment. Consulting with the patient produces the correct balance of benefit-versus-risk, factoring in the patient's own circumstances. An aggressive cancer treatment might make sense for a forty-year-old patient but not a ninety-year-old. Certain otherwise-preferred medications are avoided when a woman is pregnant. In both of those cases, the treatment itself comes at a cost of potential health risk.

In the realm of narcotic addiction, this risk-benefit ratio includes personal liberty. Some narcotic addicts stay clean and sober while in prison, yet no counselor recommends "prison" as treatment (although residential treatment has some similarities). Tapering narcotics gradually until sober is a long-accepted form of detoxification in which the patient returns to real life without a promise of "forever," but with hope for "right now."

The harm-reduction[4] argument, pervasive in narcotic-addiction treatment, states that maintenance therapy (replacing the previously addicting narcotic with a prescribed

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[1] How Long Does It Take to Get Over a Breakup? It Depends
And ... An Empirical Examination of the Stage Theory of Grief
[2] The "If It Saves Just One Life" Fallacy.
[3] The Lie of Primum non Nocere - Letters to the Editor - American Family Physician.
[4] Harm Reduction Strategies—Good or Bad for Recovery?

replacement-narcotic) should be continued for years[5] (and possibly decades) so as to prevent any possible return to drug use and (substantially less likely) subsequent overdose-death. We could look at our children the same way, and keep them indoors and "safe"—and none would ever be injured in automobile, skiing, or drowning accidents. But is that any way for children to grow?

There has to be a relationship of trust as children become adolescents, testing the waters around them. Without trying and failing, there can be no experience. Without experience, there can be no reliable knowledge. Without knowledge and experience, there can be no maturity. Without maturity there is no self-sufficiency or rational adventuring. Without all of these, there is no achievement, no meaningful work, no satisfaction. It's ironic and unfortunate (for some), but also very human, that there can be no real success without the possibility of failure.

The return to addiction, the relapse, is carefully considered, but never removed as a possibility in the treatment of the nation's single largest substance-addiction, alcoholism. Acutely, alcoholics are completely weaned from their drug of choice, booze. Unlike with recovering opiate addicts' methadone and Suboxone, there is no "maintenance" by "replacement alcohol," and no "Vodka Maintenance Clinic."

For alcoholics, there is a continuum of ancillary care very similar to that of narcotic addicts: therapy, observation, groups, counseling, and sympathy—but predicated exclusively on first having detoxed fully to sobriety. The only "maintenance" expected of recovering alcoholics is of one's calm spirit, focus, and positive direction during sobriety. Those sensibilities are maintained by adherence to the 12 Steps of Alcoholics Anonymous, usually encompassing faith in God (a higher power), devotion to family, and rededication to work.

It's debatable whether AA would ever have been created if alcoholism had been seen in the 20th century the same way opiate addiction is seen in the 21st: as (practically) a deficiency disease, requiring replacement from the same class of drug that overturned the addict's life-order in the first place.[6]

American medical and governmental coordination towards methadone maintenance began in the 1970s and has expanded in every decade since, adding Suboxone maintenance in the 2000s. Whether related or not, the various accelerated phases of the opioid epidemic coincided with increases in maintenance-treatment census and reach. The addicts' drug habit is not diminished,

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[5] Continuation and Maintenance Treatment Duration Based on Episode | ICSI.

[6] 7 Nutrient Deficiencies That Are Incredibly Common (also hormone-deficiencies such as diabetes, hyperthyroidism, Addison's disease, etc.) Endocrine Disorders: Types, Causes, Symptoms, and Treatments

only exchanged for the treatment-narcotic: methadone or Suboxone. Any stoppage in treatment yields someone still addicted and immediately hungry for new drug, whether legal or not.

Of course we don't treat every child, every adolescent, every adult completely the same. There are some for whom there should be greater caution and there are some who immediately understand. Amongst narcotic addicts, there will be similar variability. This book doesn't aim for a "one-size-fits-all" approach. It is not recommending the removal of maintenance therapy for those quite satisfied with it, or totally insecure about leaving it.

This book does acknowledge that there is more to life than receiving. People have an emotional need to contribute. Work confers dignity. The compliments and commendations received after accomplishment reinforce our best efforts. Diligence is a virtue. Our heroes in legend (and in reality) are those who accomplish tasks against the odds, through perseverance. Maintenance is a bit like it sounds, like maintaining a position and holding steady; while moving to sobriety is an *action*. All things being equal, the latter brings with it more of the heroic sensibility, "Better to have loved and lost than never to have loved at all."

This book recommends that people who are addicted give themselves the chance to believe that they can do better. While not leaving their previous problems fully behind, they may still reasonably be expected to adhere to substance avoidance as thoroughly as a recovering and sober alcoholic. That means weaning from the "drug of choice" and/or its replacement, and pursuing better avenues of actions across all aspects of life. Those in AA understand this involves living more wholesomely and simply, by means of "letting go and letting God,"[7] whereby (in tandem with mentors, family, and community) disappointments are navigated and relapses are avoided. And when they are not, they are dealt with as learning experiences, not removal forever from any later, similar attempt at sobriety.

To that end, this book's emphasis is on the "not too long, not too short, but just right" approach of multiple months of tapering of narcotic, via its milder opiate cousin, Suboxone, by prescription and in treatment. But for a patient's graduating to long-term sobriety, Suboxone, by virtue of being merely a pill and not a magic wand, requires an emphasis on "doing the right thing," having goals, and anticipating success by planning for it; and similarly and necessarily leaving unsavory (often criminal) behaviors behind. With these two tools, an actively concerned

[7] Letting go of our need for control frees us

patient, coordinating with family and friends, can step away from addiction, and ultimately addiction treatment as well.

The previously addicted individual can both withdraw *from* narcotics and *to* a safer destination: freedom from endless treatment or drug, and freedom to choose a better life. This duality gives rise to our book's title, *Withdraw to Freedom*, with the understanding that freedom, for some, is a frightening prospect, and for nearly all a persistent dream.

This book does not see a previously active addiction as necessarily life-defining or life-limiting. Former President George W. Bush conquered sobriety before entering politics. For the rest of us without presidential fathers, there will be a far different, less glamorous endpoint, but similar struggles. We aim to maximize possibilities and begin a pathway of hope.

Nonetheless, we acknowledge that there is a spectrum of drug use and individual users, each presenting different respective capabilities of surviving and thriving within a tapering-withdrawal detoxification plan. Without a crystal ball, how would we determine who is going to be successful? Somebody on a first go-round with drugs; using lower doses; or pills rather than IV might be more likely to be successful; however, should we not, theoretically, give everybody the opportunity? Even the more hardened? It seems almost prejudicial to deny them if they are willing to do it. The spiritual dimension—faith (in God and in oneself), as well as others' faith in you—can provide a pathway even for those previously lost.

There is a veil of mystery shrouding much of addiction treatment. It's unlike the more universal aspects of medical care. Everybody gets a cold, everybody gets a physical, everybody gets injured, but only a small minority receive addiction treatment, and they don't necessarily talk about it openly. This book won't open up every aspect, answer every question of narcotic addiction treatment, but it does intend to provide a perspective and a rationale for people to understand more: to become more knowledgeable "consumers" of addiction treatment and its options.

The anti-tapering argument that "relapse can bring overdoses, overdoses can bring death" omits the alternative, currently existing situation: that there is a cost in loss of life potential from the time and efforts spent in long-term maintenance, along with possible overdoses, including from methadone itself. Any abrupt stop to maintenance replacement-opioid treatment immediately returns to the pre-existing narcotic habit and a need to hunt for (often illicit) opiate drugs.

Additionally, as peer-group creatures that we humans are, recovering addicts in long-term maintenance programs may embrace certain treatment-friends' diminished expectations of returning to a life focused on accomplishment at work, home, and soul. That tapering may lead to episodes of setback (or relapse) is the pessimistic view of this approach. The more optimistic emphasizes that tapering is the exclusive route to sobriety, more alluring to those who want to leave the addiction phase of life behind.

This book does not encourage those not ready and willing. For many, maintenance is a deep comfort, and this book does not intend to disrupt those lives and treatment relationships in any way.

This book's other goal is to help families help their addicted loved ones. Partly that means learning a drug addict's excuses and often lies. "Love the sinner, hate the sin" requires a recognition of which behaviors must be shed and which must be encouraged. Expecting more from someone is a blessing for both of you. How will it end? There are no promises, but it's likely that the paths leading to greater satisfaction are more emotionally sustainable. Previously addicted individuals can bring their well-tested resourcefulness to a task that can help improve their own lives and those of their loved ones. Sobriety feels innately like, and truly is, the greater achievement. These very keen observers of their own emotions generally understand that. May this book be the vehicle, providing reinforcement and strength to pursue these greater goals.

Ready? Let's get started!

Part 1: Caught in the Web of Addiction

1. The Challenges of Withdrawal

The decision to seek help is the most important choice anyone addicted to narcotics can make. Acting on that decision with immediacy is key, but it's not as simple as it may seem. Just as our modern society offers an array of options when selecting a new phone, buying a new jacket, or picking out chips at the grocery store, there are a host of different detoxification programs an addict can choose from. Unfortunately, it's easy to become overwhelmed when faced with too many options, which can bring about anxiety and uncertainty, and ultimately prevent one from taking action.

Deciding on a recovery program without understanding its full spectrum of detoxification options, requirements, limitations, goals, and potential for long-term success is unlikely to lead to a favorable outcome. That's why this book exists: to help you understand the different types of recovery programs and to show you why my approach works where others often fail. By bringing *straightforward, transparent, and relevant* information to addicts and their loved ones, this book educates consumers of narcotic detoxification, lighting each step along the way of the recovery path. In this way, the book will reduce the anxieties that already accompany the nerve-racking and momentous decision to detoxify from narcotics.

Consumers of Narcotic Detoxification

While the phrase "consumers of narcotic detoxification" may seem to be an unusual term in this sphere of medical treatment, it can be thought of in much the same way as any other type of consumption. When we choose services or products, we base our decisions on a variety of factors. For example, when buying a car we consider different financial options: lease or purchase, pay in cash or secure a loan, and, if we elect to finance the car, we must decide on the amount of the down payment. Then there's the matter of the vehicle itself: new or used, sedan or SUV, 4-cylinder engine or something with a little more kick. When choosing a narcotic detoxification program, there are, similarly, a number of factors about which people will make

their decisions: convenience, reputation, acceptance of insurance or cost, duration, location, and ambiance.

One aspect not often considered when choosing detoxification services, yet one closely tied to the probability of success, is the level of personal responsibility required.

Personal Responsibility

Personal responsibility is a huge, but overlooked, factor in our well-being. Consider dental care, for example. Your dentist can get your teeth clean and diagnose serious issues, but the burden of keeping your teeth clean lies on you. You must floss, brush, and adhere to a regular schedule of doing so. You should avoid sugary caramel, taffy, and the like. Even if your dentist is the best on the planet, keeping your teeth healthy is not entirely in his or her power. Your pearly whites will only continue to shine as a direct result of your own behaviors, attitude, and devotion. The same goes for ending drug use: *getting clean* is the product of professional technique and skill, while *staying clean* is a personal responsibility.

Continuing with the dental care parallel, we can grant that, through no fault of their own, certain people may have teeth genetically more prone to decay (thanks, mom and dad!), while others show existing stains and damage from earlier neglectful choices. But if at any given point you want to achieve and then maintain optimal dental health, your own efforts are crucial. Returning to the dentist over and over again without having followed any of the conventional dental-care advice or without having tamed indulgences for sticky sweets will not advance your case, cause, or appearance. Only when you have gathered up the personal momentum to adhere to a schedule and hold yourself accountable will you have a lot to smile about. Upon that achievement, your smile will reflect not only your improved dental hygiene, but also the determination and all those greater efforts you, yourself, have put in.

We will be looking for no more and no less than this from those suffering from a more nefarious and nebulous form of decay: drug addiction.

For the narcotic detoxification consumer, *the level of personal responsibility each program expects is directly associated with its long-term success*. Nonetheless, not everyone will opt to take on this responsibility, especially when only casually informed of its importance. This is often because of anxiety triggered by fear of detoxification's withdrawal symptoms. Addicts may

fear they won't "have what it takes" to endure the entire process, thereby talking themselves into continued drug use. Anxiety is also triggered by the fear of increased responsibility, particularly for those addicts who have long had the consequences of their actions diluted or even enabled. Anxiety already resides in many addicts, either as an underlying cause for addiction or as a result of the stresses induced by narcotic-seeking behavior and withdrawal. Thus, many may be inclined to choose programs that appear more comforting and less stressful due to the lack of emphasis on personal responsibility.

If an addicted person is to achieve long-term success, they must be convinced of the significance of personal responsibility and of the safety and efficacy of the gentle tapering process discussed in this book.

The difficulty in making this "sale" of responsibility to a narcotic detoxification consumer (with anxiety) is compounded by conflicting societal messages. For example, there is a well-intentioned, caring impulse to help the down-and-out, to soften the blows received from poor choices and failings. However, this impulse naturally diminishes personal responsibility. Yet a converse societal sentiment exists as well: the widely agreed-upon understanding that a person's attuned self-governance leads to more satisfaction and fulfillment. Of course, with self-governing, there will be more trips and stumbles—but once you learn to walk tall, the benefits put those stumbles into proper perspective as nothing more than minor setbacks.

Let me be frank: the personal responsibility that goes along with detoxifying is not fun and entails unlearning deeply ingrained behaviors, including those suggested by subpar treatment approaches. Relearning mimics the success of having learned to walk, stumbles and all, but with unmistakable and irreplaceable pride and satisfaction on completion. Without diminishing the role of personal responsibility, this book will provide the map necessary to navigate those most frequent bumps and stumbles that are inevitable on the road to recovery. This book alone cannot repair any addicted person. Provided with clear and straightforward information, however, the no longer tormented addict can take ownership of his or her future and achieve the skills that lead to recovery.

Two Mainstream Options: Detoxification and Maintenance

There are many approaches to narcotic detoxification. We know that, if they hope to succeed, addicted people must choose an approach that is grounded in greater personal responsibility, self-discipline, and self-governance. Beyond that, there are other important considerations. One of the most important is the *detoxification timetable.* While those addicted may have a genuine, acute desire to "come clean," it is all for naught if the timetable is not geared to nurture success.

The two most prominent options are *short-term detoxification programs* (as a solitary approach) and detoxifying with a subsequent *long-term maintenance program*, which takes years to fully release addicts from narcotics and their subsequent replacement equivalents.

Both choices have severe problems that render them not only unlikely to succeed, but also potentially dangerous. The first does not allow enough time to alter and eliminate bad habits and lose the physical addiction that's built up over time; the second simply replaces one narcotic with another for *years*, keeping the addicted person frozen in a physically and psychologically dependent holding pattern.

Is there a better way? Yes, there is.

In *Goldilocks and the Three Bears*, Goldilocks famously finds the porridge that is neither too hot, nor too cold, but just right. The fairy tale's simple wisdom is directly applicable: a successful detoxification program is neither too short (rapid detoxification) nor too long (maintenance). Here we'll take a closer look at each approach, ending with what I have discovered to be the "just right" method.

Too Short

Through years of observation, I have seen that inpatient detoxification methods of a few days' length are simply too short to be effective. These short-term detoxification plans, labeled by many addicts as "spin-dry,"[89] are offered at inpatient facilities that treat acute withdrawal symptoms for only a few days. Thereafter the addicted person returns to society still dependent

[8]What Does it Mean to "Spin-Dry" in One's Recovery?
[9]Urban Dictionary: Spin-Dry

upon narcotics, albeit possibly at a lower dosage than before he or she was "spun dry" just a few days prior.

Short-term facilities offer a rigid withdrawal schedule approach that may not align with the patient's needs. There is a high degree of return to narcotic usage immediately after these short-term stays because the underlying physical, mental, and emotional dependencies on narcotics have not been fully addressed, if they've been considered at all.

Short-term facilities cushion some of the financial, physical, social, and even criminal stresses of daily narcotic usage, but don't fully address the addict's "love affair" with drugs. Most of us have experienced falling in and out of love. Falling *in* love can be euphoric, fast-paced, and joyous, yet falling *out* of love can take months of painful, debilitating recovery. So it is, too, with well-established narcotic usage, resulting in the "love affair break-ups" which rapid detoxification programs do not address.

Too Long

A second and equally self-defeating option used by many is the maintenance program approach, developed initially by methadone-based programs, and now adopted by many Suboxone prescribers as well. Methadone dispensaries, while professing to offer detoxification, actually keep clients on the same or increasing dose of methadone for years, all the while exposing clients, on their daily visits, to the same peer group from which they so desperately need escape. This encourages thoughts of previous experiences, often through rose-colored glasses.

Patients' suggestions of lowering the methadone dose are nearly always actively discouraged by maintenance providers, adding further considerable costs, direct and indirect. Lowering the narcotic addict's methadone dose fully to zero, if initiated at all, can take literally up to a decade to come to fruition. A full discussion of the problems surrounding the maintenance program approach, whether with methadone or Suboxone, will be provided later in the book.

The Bock Method: Just Right

The gradual and gentle four-month taper that I developed offers a greater likelihood of

success for a host of reasons. In roughly four months, patients are given time to initiate the lifestyle changes needed for abstinence and long-term success. They do not find themselves stuck in the quicksand environment typical of maintenance programs, defined by dependency, subsistence, low expectations, and negative peer groups. Likewise, they avoid the brutal symptoms associated with the abrupt withdrawal characteristic of rapid detoxification, which lead back to active addiction. This medium-term, practical detoxification approach mobilizes patients at their time of crisis, initially capturing and then augmenting their momentum of drug-free desires and hopes. In this way, patients are working positively and concretely toward the near-future moment, wherein they can live their best lives while receiving the appropriate and timely guidance necessary to make this a reality.

The "just right" detoxification process aims to integrate patients back into society's fabric.

Medium-term residential programs have similar timing and methods, but do so at the expense of removing patients from reality-based circumstances. Upon "graduating" from a residential program, the newly drug-free person likely lacks the ability to integrate back into a productive role. In contrast, in the "just right" Bock detoxification program, the patient is encouraged to continue to assimilate, produce, and succeed in the real world in which we must all ultimately perform.

While the "just right" Bock method sounds simple enough, I do not mean to imply it will be an easy path. *Withdraw to Freedom* serves as a roadmap to guide patients and their families through each step along the challenging journey. Without the understanding and guidance this book offers, an addicted person can either fail repetitively or, even worse, never try at all. The "just right" method offers an appropriate timetable, one acutely aware of not wasting the patient's highest motivations developed in a moment of crisis, coupled with expectations and reinforcement of personal responsibility, thereby offering the greatest likelihood of permanent success.

Why Withdraw to Freedom?

Withdraw to Freedom is an intimate communication with narcotic addicts and their loved ones. *Withdraw to Freedom* never condescends to those seeking help for addiction; nor does the book assume addicted people are not up to reaching the high standards required for success. The

steps to permanent narcotic detoxification can be distilled into three basic principles:

1. Setting and understanding limits.
2. Accepting these limits and boundaries as healthy, positive choices.
3. Adhering to limits. Unlike other programs of recovery, here we can see that bad behaviors have consequences; conversely, good behaviors bring rewards.

A committed patient who respects these three basic principles can successfully become drug-free and achieve a life unburdened by narcotics. The guidance provided in *Withdraw to Freedom* allows the reader to relax and identify with success. This book proffers a chance for the addicted person to understand addiction and, in terms rarely so candidly expressed, to see the path to recovery. The direct, open, and honest conversation addicted people are so starved for is present here and incorporates clear and applicable examples for changing one's life for the better.

Withdraw to Freedom offers an objective assessment of the array of choices in narcotic detoxification and the inherent consequences of choices made. I will dispel myths about addiction and recovery, and, with honesty and candor, inform the reader how he or she can take full responsibility for choices made. The "just right" timetable makes clear the stake the addicted person has in his or her own recovery.

Withdraw to Freedom offers help to those who want to break the shackles of addiction and achieve the goal of a life that reflects and incorporates the soul's best efforts without the downward traction brought on by the struggle to maintain a drug-induced high. This book cannot promise success in life, but it can and does go a long way in helping to avoid failure. Without the fog of drugs, people attain what they deserve and deserve what they attain. The satisfaction that comes with clarified effort is the greatest reward of all.

2. The Roots of Addiction

Before delving into how to *eliminate* the problem of narcotic addiction, it's important to understand how one arrives there in the first place. The reasons people begin using narcotics are as different as people themselves, although there are some similarities of circumstance and temperament that result in problematic addictions. Drugs and alcohol, perhaps unfortunately, are a rite of passage for many, essentially omnipresent at parties and hangouts. Teenagers, getting tastes of adulthood physically—but not fully emotionally, financially or societally—may enjoy carving out this drug-world within their real world. Their parents or guardians may be making the most important decisions about where they live, where they go, and what they can afford, but this decision, to use drugs, is made independently. Clearly, taking drugs is one decision teens take on for themselves—and potentially for others, via peer pressure.

The young person who gets high is proclaiming, "This is my body and my choice."

There's no question that teenagers learn through experience, including negative ones. Mood-altering substances provide the excitement of something different and seemingly smooth out the insecurities and awkward tensions inherent in figuring out social roles, such as one's place in the pecking order. Many teens (and of course adults) carry an inherent sense of inferiority, not feeling as liked or appreciated as they might in fact be. Drugs can be great equalizers in that sense. After all, they're called "dope" and they get you "high," so *everyone's* a little bit dopey, not as smart or as special as when sober.

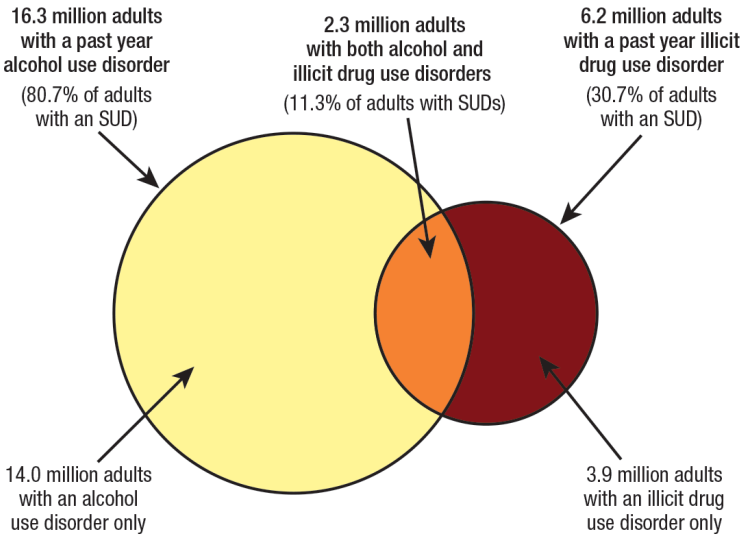
The drug high, the euphoria, can be an annealing moment, something that forges a bond between kids who might otherwise pass each other in the hall unnoticed. As with many other activities, there is some pre-selection of the crowd most prone to experiment with drugs and those more likely to avoid them. Teens with so-called "Tiger Moms,"[10] or with parents keeping close check on their activities, monitoring planned expectations of their future careers and current grades; or teens from families more devoutly religious and strictly prohibitive of drugs, alcohol, and partying—these groups will almost necessarily see the drug crowd as "the wrong crowd." They may rebel, but few do; actually, most don't desire to.

Before age eighteen, about 60 percent of high schoolers will have tried alcohol, 20 percent

[10] What Is Tiger Mom Parenting? Experts Say This Parenting Style Can Be Harsh, But Warm

marijuana, and 20 percent mood-altering controlled-substance pills.[11] Those numbers total to 100 percent, but of course that's not the case, given significant overlap. Probably, there is a solid 20 percent doing all three: marijuana, alcohol, and pills, and as much as 40 percent doing none.

Fewer than that turn into adult problem-users. Yearly, only around 8 percent of adults experience a substance-use disorder of clinical level worthy of treatment.[12] 80 percent of those disorders involved alcohol, and 10 percent narcotics; that is, around 7 percent of the adult population shows alcohol abuse (in a given year) and around 1 percent narcotic (opioid) abuse.



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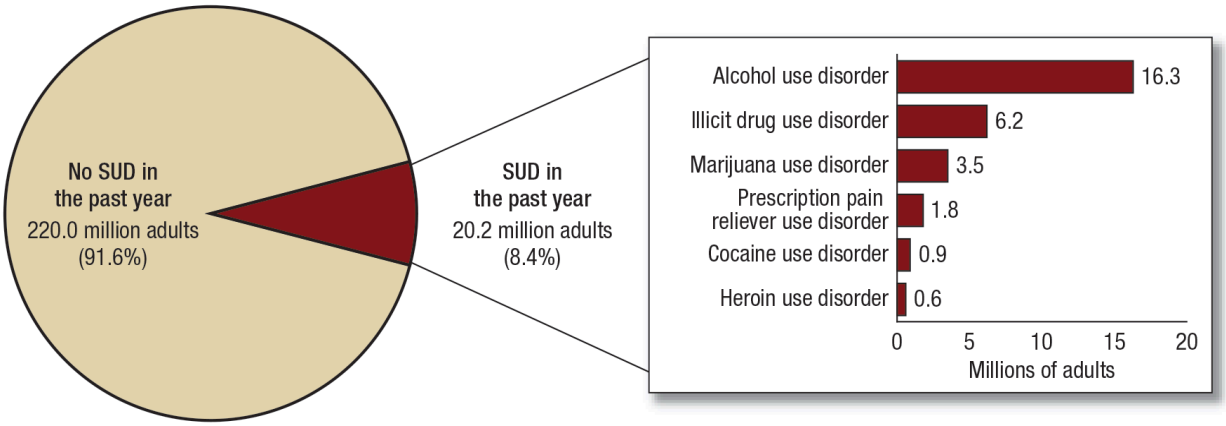

Many young people experiment with drugs and alcohol, but not that many wind up abusing

[11] Teen Substance Use & Risks | CDC
[12] Trends in Substance Use Disorders Among Adults Aged 18 or Older
[13] Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health

them. This observation comports with sociological study. In 1974 psychologist Dr. Lee Robins found the very high rate of 34 percent heroin use amongst U.S. soldiers serving in Vietnam,[14] including fully 20 percent of U.S. GIs who were heroin dependent. Those were shockingly high numbers, particularly against the backdrop of vanishingly small amounts of (pre-opioid epidemic) narcotic usage back home prior to Vietnam deployment. She tracked the soldiers' return stateside. During the first year back, fully 10 percent still had some heroin use, but after one year only 1 percent of the soldiers were heroin-addicted. That means that only ~3 percent of the heroin-using soldiers were addicted one year later, and this was without much in the way of heroin treatment apparatus socially or medically at the time (such as we have today).

Interestingly, those highly heroin-exposed 1970s, Vietnam-era U.S. soldiers equilibrated at the same ~1 percent societal narcotic usage we experience today. They reached that number without very much in the way of treatment, while today we are at no better a number with or despite a huge infrastructure of methadone clinics, narcotic treatment facilities, access, acceptance, and information.

Vietnam-era vets were not particularly well-respected or -treated upon their return. The Vietnam War was controversial, and there was considerable background scorn directed at the soldiers themselves. Despite this, very few stayed addicted to this most addictive of all narcotics, heroin. Much like our high schoolers, these Vietnam vets had "places to go, things to do" upon their return and assimilation into greater society. They were faced with more serious challenges like college, paying one's way, starting a family, entering the workforce, finding housing—in short, growing into one's responsibilities. Neither veterans nor graduates necessarily have the time or inclination for the previous level of drug experimentation and usage as during more passive and indolent times.

We have discussed what attracts people to drugs in the first place, but what keeps people on drugs? That initial intoxication and euphoria is available mostly to the drug newbie. Once the body acclimates to the drug, there's less of a kick. A lot of what you get from the 50th or 100th drug use, in a row, is merely elimination of the misery of withdrawal from the last dose. This initial repetition of the binge/intoxication experience is what brings on the addiction cycle, producing these two effects in a "lather, rinse, repeat" sequence:

[14] Lee Robins' studies of heroin use among US Vietnam veterans

1. Withdrawal/negative effect, the stage at which an individual experiences a negative emotional state in the absence of the substance; and

2. Preoccupation/anticipation, the stage at which one seeks substances again after a period of abstinence.[15]

It's possible to add more modern third and fourth stages to these phases of addiction: "drying out" and then returning to "binge/intoxication." Some addicts, once the dose gets too expensively out of hand, will attempt detox but without the commitment to fully achieve sobriety. Instead, the desire is to drop the habit enough so that the street drug will once again have its kick, bringing the highest of highs. In fact, this is one of the reasons methadone clinics are cautious about dropping clients' doses. They worry about some rebound intoxication, one that will be so high as to bring overdose, which is less of a danger when the addicted person is narcotic-acclimated, even to the methadone.

For those seeking more seemingly concrete reasons that people fall into drug-use patterns, this list[16] offers insight:

Rebellion	Grieving a death	School pressures
To be in control	End of a relationship	Family demands
To enhance performance	Mental illness	Peer Pressure
Isolation	Environmental influences	Abuse and trauma
Misinformation	Relaxation	Boredom
Instant gratification	Self-medication	To fit in
Wide availability	Financial burdens	Curiosity
Ignorance	Career pressures	Experimentation

Emotional aspects of one's personality are of course intermixed with the physical aspects of the cycle. We all certainly experience positive and negative reinforcement, believing we'll obtain some type of reward or avoid punishment as a result of our actions. Continued drug use and frankly stopping drug use can both work off these principles. During drug use the positive is getting high; the negative is in avoiding the low. Later in recovery, the positive reinforcement

[15] ." THE NEUROBIOLOGY OF SUBSTANCE USE, MISUSE, AND ADDICTION - Facing Addiction in America - NCBI Bookshelf
[16] https://emeraldcoastjourneypure.com/top-reasons-people-use-drugs/

comes from the mature satisfaction of avoiding this whole cycle of repetitive tensions, and the negative reinforcement is guilt over having relapsed.

Behaviorally, impulsivity and compulsivity factor in towards one's likelihood of becoming addicted and staying addicted, respectively. *Impulsivity* is the inability to resist urges and delay gratification. It is a tendency to act without regard for consequences and to prioritize immediate rewards over long-term goals. *Compulsivity* represents repetitive behaviors that are inappropriate to a particular situation. People suffering from compulsions often recognize that their behaviors are harmful, but they nonetheless feel emotionally compelled to perform them.[17]

The way out from these two is a difficult, long, often repetitive process of attempted experiential learning: trying and failing; trying and failing; trying and succeeding! As with any great task, there are many falls along the way.

This book, of course, doesn't guarantee success on any given attempt at detoxification, but it serves as the manual for getting those steps down with the underlying message that success cannot be achieved without trying. There can be cautious comfort in continued maintenance, and for some, attempts at withdrawal may seem reckless, but in one's life, heroism resides in courage, a virtue.

Recovering addict, RN, and interventionist Joani Gammill challenges the conventional belief that if a (drug-) rehab did not work, it was a failure:

> Recovery from opioid addiction is a process, not an event. "Failed" stints in rehab centers actually form the building blocks of progress that one day lead out of the depths of opiate addiction. Getting well from this disease does not often happen in one event, one rehab, one detox, one Twelve-Step meeting, or one outpatient treatment. As with some other diseases that require multiple forms of treatment, it can take many different treatment attempts and modalities to gain long-term sobriety."[18]

Remember, humans (and all other animals) learn best through experience. Richard Branson had many failures before hitting on Virgin Airlines and then later spaceflight: "You don't learn to walk by following rules. You learn by doing, and by falling over. Do not be embarrassed by your failures, learn from them and start again."

Your life can "take flight" as well. Don't fear the embarrassment of failure, look forward to the success through knowledge.

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[17] GLOSSARY OF TERMS - Facing Addiction in America - NCBI Bookshelf
[18] "Painkillers, Heroin, and the Road to Sanity: Real Solutions ..."

3. If You Think You Have a Problem, You Do!

Recognizing that addiction is present is the first step on the path to recovery. Although most people regularly taking narcotics are aware a problem exists, it is nonetheless helpful here to spell out the characteristics of addiction in black and white, both to reinforce its presence in the mind of the user and to help outsiders identify concerning behaviors. This chapter, then, categorizes and explains life disruptions associated with narcotic usage and continues our discussion on how to achieve long-term recovery and the restoration of a drug-free existence.

The realization of addiction's onset will be apparent sooner to the narcotic user than it will be to family or friends. Initially, only the narcotic user may be able to perceive his or her growing dependency on the drug; however, as the severity of the addiction increases, outward symptoms will become more noticeable to others.

Recognizing the Signs of Addiction

For drug users and the people in their lives, being cognizant of the indicators of addiction can prove very helpful in corroborating the presence and severity of the problem. Family and friends of the addicted person may otherwise be unaware of the reason for the strange and furtive behaviors often exhibited. A quicker, authoritative recognition of the problem will aid in bringing about the needed determination to help the person in trouble.

The warning signs of addiction fall into two basic categories: 1) The more inward, personal, physical symptoms, potentially visible to only a very astute observer, but easily masked by a dedicated, secretive, or crafty user; and 2) The more outward behavioral and social warning signs potentially more noticeable to an informed observer than even to the addicts themselves.

The following list of addiction signs is subdivided into two categories, inward (personal) and outward (potentially public), with the understanding that there is clearly some overlap between the two groups.

Inward Symptoms

Noticeable to the addicted person after narcotic dosing: Fatigue, somnolence (sleepy appearance) including nodding off and/or sleeping too much, slow or slurred speech, disorientation, small aperture ("pinned") pupils irrespective of low ambient light.

Noticeable to the addicted person during narcotic withdrawal: Rapid speech, excessive energy, trembling hands, anxiety, runny nose, cough, cold symptoms, oversensitivity to sound and light, dilated (enlarged) pupils, insomnia, fitful sleep.

Noticeable to the addicted person, in general: Change in appetite or weight, headaches, irritability, neglect of personal hygiene and grooming.

Outward Symptoms

Financial: Unwarranted selling of private property (or worse: shoplifting, theft, scheming, scamming for money); earning wages, yet having no cash or savings remaining; high priority bills (rent, shopping, car payments, insurance) left unpaid; endless "borrowing" without repayment; stealing money from mom's purse.

Social: Isolation; loss of interest in past activities (sports, hobbies, church, community, parenting); poor task performance (school, work, errands); irresponsibility; lack of reliability; being caught in lies.

Mental health: Mood swings (more than usual); prominence of snippy, irascible, difficult, non-contributory, selfish characteristics; secrecy about comings and goings; increased paranoid tendencies.

Objective: Presence of paraphernalia such as needles, baggies, pill bottles, tinfoil; obvious absence of cash, possessions, painkiller prescriptions; increase in contacts, telephone calls, and messages, oftentimes with "the wrong crowd" and of almost a business-level nature, without an actual business's existence; noticing strange people or kids coming to the house looking for your child; unpaid debts; strange charges to checking and/or credit card accounts; and (the most obvious) finding drugs in the house or amongst possessions or receiving verbal confirmation directly from the addicted person..

The signs of addiction are variable from moment-to-moment and can be further divided according to the timeframe of occurrence:

- After narcotic-dosing: quieter, often personally-pleasing symptoms (mostly of the sleepy/drowsy variety).
- During withdrawal: agitation, muscle aches, excessive sweating, runny nose, eyes tearing up, excessive yawning, diarrhea, and vomiting.

In conjunction with the aforementioned physical symptoms and social behaviors indicative of the presence of problematic, addictive drug use, there are further, coarsening behaviors recognizable as drug use becomes more entrenched and consuming:

- The need for greater doses of the narcotic; fear of running out.
- Excessive time spent thinking about ways to get more money or drugs.
- Stealing, scamming, prostituting, cheating, and "borrowing" to get money or drugs.
- Doctor-shopping: fraudulent obtaining of overlapping narcotic prescriptions.
- Feeling severely ill when off drugs; substituting one opiate for another.
- Missing work and/or family events; failing to deliver on promises.
- Lying about or concealing usage.
- Injecting drugs—this is not the behavior of the casual user. Insistence on keeping arms covered to hide needle marks.

These behaviors represent and should be recognized as indicative of a serious addiction problem and very possibly deeper character issues as well. Those who are capable of dangerous or fraudulent actions, even if we acknowledge their performance in pursuit of a goal (obtaining money or drugs), will not necessarily progress emotionally or socially if those actions are ignored, discounted, or too easily forgiven while attributed solely to an addiction.

Awareness and understanding of the addiction signs thus far described can help deter early narcotic usage before it blossoms into full addiction. Similarly, a speedier recognition of addiction's onset will marshal recovery efforts sooner.

Once addiction's existence and the necessity of resolution are acknowledged, will a remedy quickly follow? Does the drug user typically take a newfound desire to stop doing the drug "right to the bank," i.e., immediately have the problem attended to and fixed? Ideally that would be the case, but for many, even as the road to recovery is seemingly a desired path, ambivalence delays action.

Here is an example I encountered in my practice:

Joe Smith, as I'll call him, was a fifty-two-year-old plumber taking Percocet and OxyContin

for ten years. He asked to start substance abuse treatment. When asked, "Why now?" his immediate response shifted the blame to his circumstances. He told me his marriage had ended a few months ago, and he started every morning feeling worthless and lousy.

Choosing to move past that response (for the moment), I asked him why he had not sought help before, when the marriage had first ended or even before it did. Joe was quick to blame his (newly) ex-wife as an enabler who, as a successful professional, provided the financial means he needed to obtain drugs. As the office visit continued, he slowly began acknowledging his own role in the addiction he now faced. Before he left, he admitted that everything boiled down to one simple truth: He liked how he felt when he was high and didn't know how to stop.

Roadblocks

The road to recovery is certain to contain roadblocks. Joe's primary obstacles were denial and the urge to shift blame, and these are not uncommon. Other roadblocks, that vary in nature and seriousness, can also delay recovery (or prevent it altogether), including:

- Low threshold for pain.
- Inadequately exercised personal willpower.
- Fear of withdrawal.
- Nervousness over a possible failure to complete detoxification.
- Inability or lack of desire to break bad social habits.
- Ignorance of the programs, tools, and means of escape from narcotic use.
- Entrenchment in the lifestyle typical of an addicted person: the exciting, void-filling, near-endless hubbub of activity of procuring and consuming drugs masking the painful absence of a healthy life.
- An unwillingness or inability to achieve social success yielding to time filling and perversely exciting "drug life" activities (often hard to give up) such as:

Connecting with the dealer; arranging "favors;" side-deals.

Begging, borrowing, stealing, scrounging, scheming, skimming, scamming, and juggling doctor appointments and prescriptions.

Getting high: the ultimate, calming, "reward" for all this ill-begotten activity.

In light of such issues, trepidation over beginning what some perceive as an impossibly

difficult journey from start to finish becomes partially understandable to the outsider. Be careful, though: acknowledging the existence of fear doesn't mean that it is permanent or insurmountable. Recall President Franklin Roosevelt's famous inspiration to America in 1932: "The only thing we have to fear is fear itself." Less well known, but more to the point for our discussion, is his accurate categorization of fear as an "unreasoning, unjustified terror which paralyzes needed efforts to convert retreat into advance." While FDR was referring to fear in the context of the Great Depression's grip on society, the thought of not allowing fear to postpone actions towards success is equally useful in addressing the personal "Great Depression" that drug addiction entails.

Previously immobilizing fears can be dissolved with proper understanding of a few basic facts and ideas.

Narcotic detoxification to full sobriety is safely attainable even within short time frames. For example, an addicted person sent to jail for a month results in a few days of severe discomfort, but without lethal consequences. Stretching and diluting that discomfort over a few weeks or months represents a reasonably tolerable physical proposition. It's worth pointing out here that criminal behavior and activity are not inherent to narcotic usage and should not be excused as such.

There is no innate or inextinguishable "disease" that is relentlessly forcing people to start or restart narcotics. Addiction is a disorder of choice.[19] For instance, if you locked a diabetic and heroin addict in a prison cell and gave them only food and water, the genuine type-1 diabetic would die, while the heroin addict would look markedly better after a week of being miserable.

People make many choices in life; not all of them will be the smartest choices, but it is possible to benefit from mistakes and carry forward with more fortitude and wisdom. People do not just passively get hooked on drugs so much as they hook themselves. The very analogy of getting hooked brings to mind what happens to fish who encounter an attractively baited free meal, unaware of the barb concealed within. In the case of humanity, however, there is no plausible way to deny the presence of the hook. An addict's accelerating narcotic usage is done so knowingly**,** with users being fully aware of the addiction potential but enjoying narcotics (at least initially) either as a high, an escape, or an excuse. As such, people are fully capable of outgrowing addiction with proper motivation and the understanding of the greater successes that

[19]REVIEW OF HEYMAN'S ADDICTION: A DISORDER OF CHOICE

come once addiction is left behind.

Once these fears are encountered, addressed, and (hopefully) dissolved, the soon-to-be former addicted person is on his way to crowning a great effort with a well-deserved accomplishment. It would be a mistake to underestimate the power to attain sobriety in those who are now properly motivated, focused, directed, and educated. What can seem initially and outwardly difficult, if not impossible, can be, once armed with proper intelligence and direction, quite achievable.

In sum, recognize the problem; understand its dimensions, potential for damage, and danger to the user; determine the best course of action and the best means for extrication... and then *do it!* These actions form the overall plan and thesis of this book.

Dependency vs. Addiction[20]

In the addiction-world, there are two terms, "dependency" and "addiction," that mean practically the same thing. We will cover them not as an endorsement of this distinction, which ultimately makes very little difference in the narcotic user's situation. Not everyone who is *dependent* on a drug is *addicted* to it. In order to address this issue, it is pertinent to understand the different types and levels of narcotic habituation and the paths that led to it in the first place.

Dependency

Dependency is a physical need for opiates usually being prescribed by a physician. In dependency, the behaviors associated with addiction are not present; for instance, buying illegal drugs and scheming to get the money to do so. Nonetheless, dependency carries its own set of problems. Many people who are physically addicted to opiates, perhaps through medical over-generosity of painkillers, progress to addiction through legal, accepted channels, late to realize an unintentional, "no-fault" addiction has manifested. Their lives and behaviors nonetheless have come to be directly influenced and controlled by narcotics, albeit prescribed. While the criminal, unsavory behaviors may not occur in dependency, the physical and psychological symptoms will. Our brains, on a cellular level, are unaware of a given narcotic's legality, but very aware of its potency, and aware again of its later absence.

It's an unfortunate truth that daily exposure to opiates creates habituation; and, in the case of

[20] Is there a difference between physical dependence and addiction? | National Institute on Drug Abuse (NIDA)

dependency, habituation's occurrence in the context of doctor visits and a medical diagnosis can make it harder to self-acknowledge. Those taking narcotics by prescription are typically urged to consider literature describing addiction symptoms, and to look for similarities. This information, coupled with feelings and suspicions, can guide a clear conclusion regarding the condition. Most people dependent on narcotics, it is generally thought, need some assistance in getting the drugs out of their system, but the amount and type of assistance depends on that person's own desires. Higher levels of internal motivation coupled with higher levels of external pressure from friends and family yield a greater impetus for improvement and change.

While a strong, addictive painkiller prescription is occasionally warranted (after physical trauma, for instance), close examination often reveals most long-term painkiller narcotic prescriptions are *no longer treating the original pain*. Instead, the therapy is continued to avoid the physical and mental pains associated with narcotic withdrawal—pains that this book can help conquer.

In these cases, talking frankly with the physician who is prescribing the narcotic is strongly recommended, possibly with this book in hand. Some should consider switching to a doctor who is fully aware of the speed of occurrence of habituation and the dangers inherent in medical narcotic dependence, and who is leery of long-term narcotic replacement. No one should suffer needless pain acutely, yet no one should be led down the road toward needless dependency either, with the potential of a spiraling physical need, increased narcotic dose, the omnipresent price (whether emotional or literal, and likely both), and narcotic withdrawal symptoms (discomfort, dysphoria, and depression), none of which can be avoided.

It should be noted that most people who are prescribed a narcotic on a short-term basis do not typically become dependent. This can be mostly attributed to the convictions and lifestyle of the person receiving the prescription, not the medication itself. We all know very well how to stay away from danger, but some people choose to pursue it. Consider, for example, a married man who faces sexual temptation at work; he has a choice to either commit adultery or uphold the marriage commitment. One choice invites chaos and trouble into his life, while the other keeps the peace. If the man chooses fidelity, it does not negate the fact that he has eyes, yearnings, and desires. It simply indicates that his convictions and maturity allowed him to recognize that the momentarily satisfying sensation of sex was not worth risking his marriage. And so it follows with addictive drugs.

Addiction

Addiction, while clinically identical to dependency, is often far easier to identify and harder to deny. All or most of the underlying behaviors are present, there is no legal prescription to point toward, *and* addiction typically includes illegal activities absent in dependency.

Detoxification rates are better in cases of dependency than what is seen in addiction, despite the detoxification process being identical for both. The differing rates are a result of what is commonly called *selection bias*.

Those who become medically dependent on narcotics and arrive in this state unwittingly are, for the most part, less difficult to treat. Imagine a CEO of a large corporation has been prescribed a painkiller post-dental surgery. This person (at least stereotypically), is leading a productive, organized life. He has commitments and obligations. People rely on him. It's not a far stretch to believe that, should dependency set in, he will seek help quickly and not permit his way of life to be threatened by the drug.

On the other hand, those addicted to narcotics have almost always arrived by way of an acted-upon desire or an appetite for the drug's effects, rendering their success at detoxification substantially less likely. Here, imagine an undereducated individual, perhaps working odd, part-time jobs as needed, but never gaining any real traction in life. He lacks the inherent motivation to work hard or to sacrifice immediate gratification for the benefit of the future. Even when offered treatment at no expense, he is unlikely to accept help, much less follow through.

Of course, these examples are extremes, but most people align themselves with one over the other. These distinctions may very well help relatives and close friends of the narcotic user better understand the exact nature of the situation, reducing misguided feelings of guilt and shame. These are common sensations for those close to a narcotic user, but not necessarily deserved. In most cases, the friend, spouse, sibling, or parent is not responsible for a narcotic user's drug-seeking behavior.

In the short-term, it makes little physical difference how the present circumstances arrived. A body's craving for narcotics doesn't distinguish between a pharmacy or a street-corner; it simply demands to be fed. The gently tapering detoxification program outlined later in the book is identical for the medically dependent as for the street-drug addicted. This slow, supervised taper, when accompanied by suggestions for behavioral changes, guides smoothly to a completely drug-free existence.

Advice for Family and Friends of a Narcotic User

Support and encouragement from friends and relatives are crucial to a successful recovery. These efforts are best when they are not colored by guilt and shame. In fact, support and encouragement are most effective with the understanding that recovery from addiction is a self-directed, personal journey accomplished by the narcotic user. The support system of friends and relatives solidifies the emotional base for those making the effort to leave narcotic usage. Along with guilt and shame (which are inward emotional results), support-system members' other natural (outward) feelings of anger and bitterness may arise and in fact last long after users have changed their ways.

The preferred position, emotionally, for friends and relatives to undertake is that of *referee* rather than *teammate* or *coach*. For those who have long been very emotionally absorbed in the ups and downs of a family member's narcotic usage, the role of referee can be a difficult one to assume, but it is ultimately the best approach. A referee is impartial, having no allegiance to either team. A referee instead seeks objectivity, "making the calls" based on fact. In the long run, the players do best by having a uniform set of rules and codes of behavior, where adherence is rewarded and violations penalized. A referee can't run the ball, score the touchdown, shoot a basket, get a goal, or fumble. Referees, in fact, shouldn't get emotionally involved at all in the process. Every referee probably has a favorite team, yet no referee can ever reveal which team that is.

Assuming the role of referee is not as challenging as it may sound. People need merely to know how that can be translated into real life dynamics. Here is an example.

I received a phone call from Barb, the girlfriend of a middle-aged male patient, Josh, who'd just begun the detoxification process. A foster parent many times over, she expressed concern that her natural tendency to nurture could get in the way of Josh's progress. I asked a simple question, drawing from her experience raising children. "Would you reward your children with cookies *before* they'd completed their chores?" The lightbulb went off, and I suggested applying the same sensibility to her interactions with Josh. I also gave her these tips:

- Keep an eye on the bank accounts.
- Don't over-sympathize by assuming stopping narcotics is overly difficult. People motivated to lose weight can drop hundreds of pounds; similarly motivated addicts can stop their

narcotics. Like weight loss, think of this as "drug loss."

- Don't dissolve problems, deal with them head on. Merely endeavoring to stop drugs doesn't mean other problems will stop occurring. When they do, talk them through. Don't accept drugs as a needed or justifiable escape from reality.
- Willpower is an under-used "muscle" for many, but will become stronger with use.
- Do not encourage bad behaviors. If they do occur, don't reward them. If they occur repeatedly, your relationship must be evaluated.
- Set hard goals, then stick to them.

There is a modern societal emphasis on self-esteem, wherein there is implicit approval of almost any action. A few parents fall into the trap of universal applause and approval, becoming their children's cheerleaders or friends. Successful parents understand, over time, that children are not looking for continued approval for each and every action, but rather for a uniform code of behavior. Children won't accomplish any personal growth if they are not brought up in a system that rewards better behaviors and disapproves, in some way, of less desirable ones.

Most people reading here will know about *enabling* and *codependency*, which are common terms in the world of addiction. It is crucial to keep in mind that excessively permissive and compliant behaviors put the preoccupied caretaker's needs subservient to the user's. Sympathy for a narcotic addict's moments of vulnerability, such as during withdrawal agonies, can erode the justifiable anger felt during a just-prior drug purchase's blowing a hole through the household budget. It is important, but difficult, to insist to yourself that behaviors that wouldn't be tolerated from a twelve-year-old should not and cannot be tolerated in an adult, despite the painful and pitiable situation so often manifested in withdrawal.

Understanding Enabling and Codependency

Addiction and substance abuse issues don't just affect users. Family members and friends also suffer consequences, and the effects can be long lasting. Besides the obvious problems like fearing for the addict's safety, questioning his motives, and suspecting theft as a means to procure drugs, it is easy to fall into enabling and/or codependent behaviors.

When someone in the addict's life encourages his drug use, directly or indirectly, this is called *enabling.* A common example of *indirect enabling* is when spouses hide their husband's or

wife's addiction problem from family and friends, often lying on their behalf. Clearly, lying to save someone from embarrassment is not the same as saying, "Hey, why don't you run to the bathroom and get high?" Nevertheless, the message the addicted person hears is effectively the same: "My addiction is acceptable to my spouse."

Giving or loaning money to the addict is an example of *direct enabling*, because even though it's unlikely the money is expressly given for the purchase of drugs, all parties know that's most likely what the money will be used for.

Codependency is when someone in the addict's life allows themselves to be controlled by the addict's behavior. This happens when someone close to the addict believes that their relationship depends on doing what the addict wants. For example, parents who believe they cannot allow their adult child to live on the streets, and provide them with shelter and food, are making decisions based on the addict's wants, needs, and demands. Instead, the parents in this situation should refuse to allow their adult child to live in the home while still using drugs. Preventing the addicted person from experiencing the consequences of his or her actions will not lead to recovery.[21]

These sympathetic feelings are natural but must be kept in check. The narcotic user naturally appreciates love and concern but has the greatest chances of changing for the better if egregious behaviors are deemed unacceptable, not swept under the rug. This is not to say it is the responsibility of family or friends of the addicted person to "punish" bad behavior, only to point out the best changes will occur on their own as the person recovers thanks to their own personal, best intentions. It is a long, sometimes painful journey, and you can hope for and encourage its success, but you cannot force it.

Many addicted individuals, who were essentially written off by family and friends, come to lead full, productive, and healthy lives. There is always hope, and there are winning approaches that maximize hope. I will be emphasizing these throughout this book, advocating short-term Suboxone detoxification and complete abstinence as a goal. Being armed with the knowledge in this book will help you choose a doctor who will allow you to achieve the same goal: One hundred percent freedom from addiction.

This book addresses many types of dependent people, from those who are street users to those whose medical pain management has crossed the line into substance abuse. Some schools of

[21] https://www.mentalhelp.net/blogs/codependent-and-enabling-behaviors/

thought imply that *any* narcotic habituation that is difficult to dose-diminish constitutes a disease requiring years of both medical and psychological help.

My experience is this: whatever underlying emotional or psychological issues may exist, the physical aspects of narcotic habituation are one hundred percent reversible.

4. No More Excuses!

*"*Gonna kick tomorrow" is the classic refrain from a song by Jane's Addiction, and it expresses perfectly the sentiments of many addicted people, but it is not good enough.

There is no time like the present.

If you've read this far, there is every reason in the world to continue pressing forward and absolutely no reason not to! This chapter illustrates some typical excuses I hear from addicts concerning why *right now just isn't the best time* to begin the recovery process. To the contrary: It is *always* a good time. There is no question that narcotic usage's adverse effects on the lives of addicts and family, and even neighbors and society at large, are traumatic. Here, I will begin to remove and counter the psychological barriers and excuses many patients have when taking the first step on the road towards recovery.

Blaming Anxiety

I interviewed a couple who expressed genuine desire to detoxify from opiates. This was great news, but it was marred by their shared unwillingness to give up Xanax. A somewhat common prescription treatment for moderate to severe anxiety and panic disorders, Xanax is a tranquilizer of the benzodiazepine class. Its effects on the body are similar to those of alcohol: initially seemingly clarifying, overall relaxing, but ultimately addictive and detrimental to success for the narcotic-addicted. The irony is that when the tranquilizer's dose runs out, there can be a worsening of anxiety and panic.

Anxiety has a physiologic basis, rooted in the "fight or flight" mechanism common to all animal species. The common signs of an anxiety attack—fast heart rate; shallow, quick breathing; a sense of dread; a sensation of a drop in the pit of the stomach; even creepy-crawly skin—coincide with the methods the body possesses and engages in to "rev up" in anticipation of one of the two options available when the animal is surprised or under attack: a "fight" or a "flight," that is to say, fleeing or running away .

Let me further explain. If a cat were surprised by a small animal, such as a mouse, the cat would take on a *fight*. If the cat were to be startled by an animal larger than itself, for instance one of us, the cat would likely *flee*. In either case, the feline's heart would start beating fast and

breathing patterns would change in anticipation of fight or flight.

A while later, after either of those two options had faded into the past, the cat's hormones would have returned to their normal levels, restoring the cat to its relaxed state. So, essentially, the fight or flight (or anxiety/panic) physiological changes are dissipated following the scenario, allowing a relatively smooth transition to the normally quiet state of the cat (with no Xanax!).

So goes the animal world, which is obviously different from our own. If a tomcat were to find himself part of a greater societal grouping of cats who frowned upon fight or flight, the cat might very well become perplexed and might well indeed manifest anxiety. This is the case within humanity's societal grouping (the one we call modern civilization), wherein the ancient and instinctive fight or flight response is (to say the very least) frowned upon. When you tap somebody who is off in his own orbit, say listening to music with earbuds, that person will startle and can look shocked and annoyed, but can't throw a punch. Likewise, he would appear strange and furtive, possibly even criminal if he took off running immediately at top speed (such as would any sensible cat in the same situation).

We all experience moments of being startled. The degree to which our own engine "revs up," the degree to which we start exhibiting the signs of fight or flight, or of anxiety, depends on the situation and on the personality. Somebody in a highly suggestible state—for instance, watching a vampire movie in the dark—might very well shriek if startled.

The cat regains his quiet state after quickly working off his hormone-fueled energy; the nervous basketball player after ten minutes in the game. In both of those cases the quiet restful state is restored by burning up the extra energy.

But a tranquilizer like Xanax doesn't burn up this extra energy; it *tranquilizes*. The problem here is that it comes at a price. By tranquilizing the fight or flight energy instead of working it out the natural way, the body develops an expectation of being sedated. With tranquilizers ingested frequently enough, two problems are created: a new behavioral track of expectation of tranquilizer, and a physical tranquilizer tolerance or drug-debt.

For civilized humans, the immediate working off of energy from fear via fight or flight is often not an option. The addicted person who suffers from anxiety may need to be guided to incorporate more exercise and generally augmented physical activity, including work, to discover and lessen the triggers of panic. Often, just getting away from the haphazard, free-fall

lifestyle of the drug-world will disperse many of anxiety's causes.

The best way to deal with anxiety is of course not to have it, or to have less of it; and the best way to avoid it is to be more in control of your own personal situation and less worried about external things happening to you. Again, touching on animal-examples, think of a lion and a mouse. If like the lion, you are the motivating force that "happens" to the world around you, then you will have less anxiety. A vulnerable mouse must be more wary, furtive, and yes, anxious. That's sensible for the mouse, but if you had the choice, which of these two animals would you rather be?

When the drug problem gets out of control, it's out of control on a number of different levels—emotionally, socially, financially. All of that furtive action, lying, scrounging, making do, figuring out places to stay, places to steal, places to hide out—all of those are the trappings of anxiety, and all of those are anxiety's trap. No one lives a life without any worries, without any anxieties, but when we search for peace and happiness, generally we're thinking of ways to minimize those worries.

There's the old expression "money can't buy happiness." That may be true, but it sure can buy the space, peace, and quiet functioning of the personal sphere of life around you in which you can achieve it. Knowledge of your situation and of how to avoid distress and anxiety-producing situations really is the key to ending addiction cycles.

For many addicts, the coincidence of anxiety and addiction can complicate entry to full-sobriety detoxification. There rarely a compelling, overarching medical reason to keep one's "security-blanket drug" such as Xanax or marijuana, and frankly, good psychological reason to get rid of it by learning to cope with one's problems without drugs. In cases such as these, I recommend a concurrent supervised taper. The goal is to become drug-free, not to substitute or juggle addictions.

This does not apply to appropriate, non-addictive, therapeutic medications such as antidepressants, for example. Always consult your physician about any aspect of your prescription medication! Prescribed anxiolytic medications such as Xanax, Valium, and Klonopin can be helpful if taken appropriately and as directed. But when should we consider issues with these medications problematic? Well, does the anxiolytic-medication user self-represent as somebody with a problem? Does she see difficulty or inability to continue with her current situation? Is she going outside of the prescription/medical world in order to

obtain it? Likely not. Is she "letting the tail wag the dog"? Likely not, again.

Let's look at a very similar example: alcohol. Basically, alcohol and the benzodiazepines (Klonopin, Valium, Xanax, et al.) functionally act almost identically in the body by slowing down neuronal conduction and "calming things down" through the actions at the very same GABA neurotransmitter pathway.[22]

Alcohol is easily obtained, no prescription is necessary, and people drink beers at barbecues and wine with dinner. Not a problem. But then we all pretty much know what an alcoholic is: somebody who has turned life upside down in pursuit of alcohol as an escape from actual, important dealings and functions, making the world temporarily and artificially disappear, albeit with worse consequences once the haze is gone. As with narcotics, the problem is not so much the thing itself as the way in which it is used or overused: presenting an axis of abuse of one's own sensibilities, hijacking our best and most efficacious social pathways to success. This goes for all of our other enjoyable semi-obsessions: food, gambling, sexual relations, video games. Moderation = good, excess = bad. Where are the lines drawn? Well again as above, when the "tail wags the dog."

Other Excuses

- "What about my pain?" (Chronic drug use doesn't fully get at the pain, it's in large part covering withdrawal; ironically some of the pain is from withdrawal.)
- "All my friends use." (Excitement for all the wrong reasons, getting into "the life," the action, the excitement of having to procure drugs, black market. Does this ever end up well?)
- "I'm scared of withdrawal. I don't want to get sick." (This is manageable. People get over their addictions, alcohol, tobacco, drugs, gambling. Not always easy but nothing happens unless you try.)
- "Drugs are what make me feel normal." (Let's fix that. Let's get a more ordered life around you.)
- "My narcotics and tranquilizers are prescribed." (But overused, bought and sold, running out too soon and causing lies.)

[22] "Distinct actions of alcohols, barbiturates and benzodiazepines ...." https://www.sciencedirect.com/science/article/pii/0741832990900177. Accessed 19 Aug. 2020.

- "I really need to think about it more." (Possibly stalling.)
- "I don't really have a problem; I can control it." (Okay, prove it.)
- "Marijuana is almost legal (or legal); it's no big deal." (But certainly not helpful, particularly if used with other drugs.)
- "I could stop any of these whenever I want." (Why haven't you?)
- "I can't afford detoxification." (But can you afford a life of more drugs?)
- "If I try detox, I'll just relapse. Why bother?" (Why, indeed? Because there is of course the chance you won't fail).
- "I can't help it. I try but keep going back." (Acting as if you don't have a role in how things transpire.)

5. Addiction Is a Disease… Right?

The debate over whether addiction is a *disease* or a *behavior* directly influences how it's treated in the short-term for the individual addict and in the longer-term for society as a whole. What might seem like a philosophical point best left to experts actually represents a distinct fork in the road. Those who view addiction as a disease are likely to choose a recovery path that requires less personal responsibility. As you already know, this is a recipe for failure. On the other hand, those who view addiction as a behavior know that making a change is a responsibility that lies largely in the hands of the doer, albeit with some help and support provided along the way.

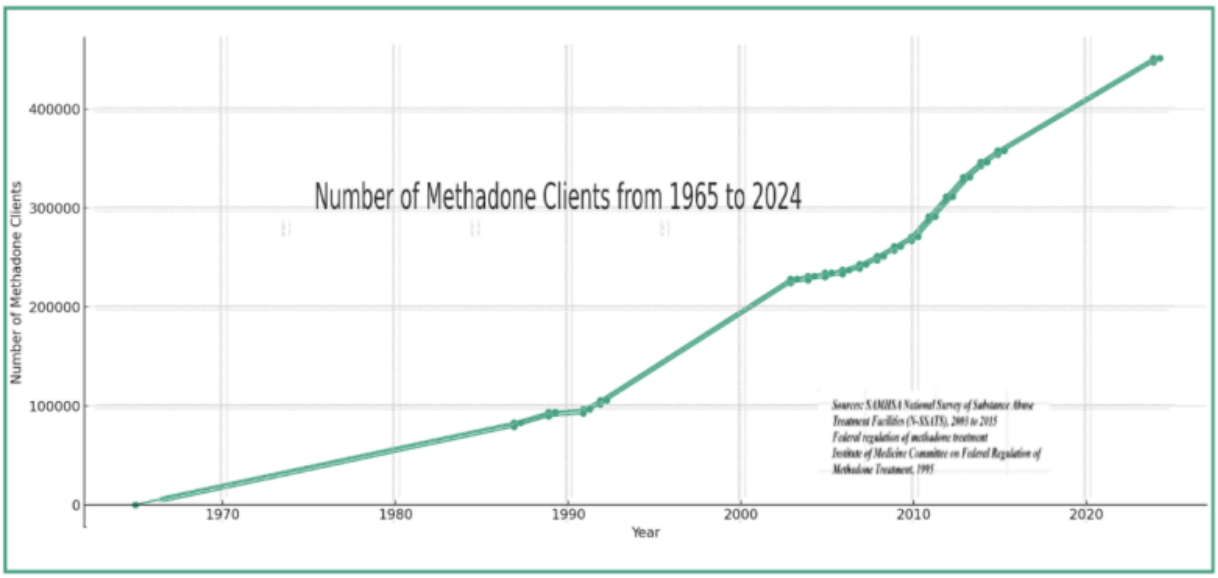
So, what are the distinct differences between these two approaches to the same problem?

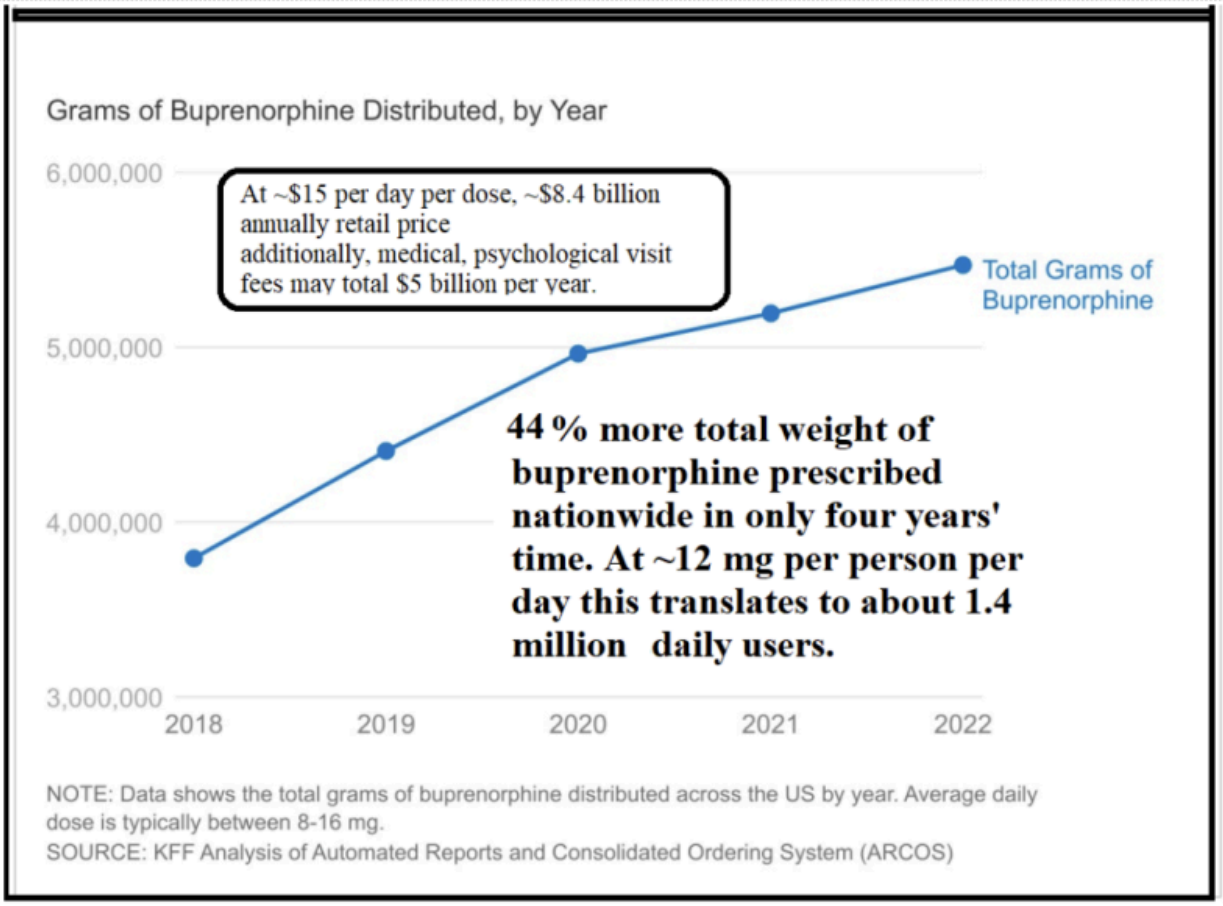
The disease theory of addiction sees an individual's narcotic usage as the outward result of an underlying biologic disease, dormant until awakened by life occurrences, and, once awakened, becoming a lifelong problem the individual can never eliminate, only temporarily control, with ongoing therapeutic supervision. By this theory, even a newly addicted person will be unable to reach or maintain sobriety without continued medical help, a situation analogous, say, to a cancer patient's inability to "fight back" without radiation or chemotherapy.

The behavior theory sees addicted people as entirely capable of rejecting and overcoming addictions, pointing to the long human history of independently taking on and then rejecting personally unproductive behaviors. People learn from their mistakes and train themselves to do better, though often after some failures or a fair amount of trial and error. A finding that is in favor of the behavior theory is that *diseases* like diabetes have been with humans essentially forever; on the other hand, narcotic usage *behavior* in areas distant from opium cultivation was nonexistent until the advent of distribution networks, and has exploded since.

The total amount of narcotics available and consumed—what could be called the "narcotic GDP" (as in economics, the "gross domestic product")—has been constantly growing over the last fifty years, partly because of effective criminal drug distribution networks. They are far advanced from the original trans-Asiatic caravans and ocean-going ships, and now present as heavily financed, high-tech smuggling cartels that have at times corrupted and co-opted law enforcement and even entire (foreign) governments. In addition, an unintentional boost in narcotic usage has occurred through legal channels with the enormous growth in medically

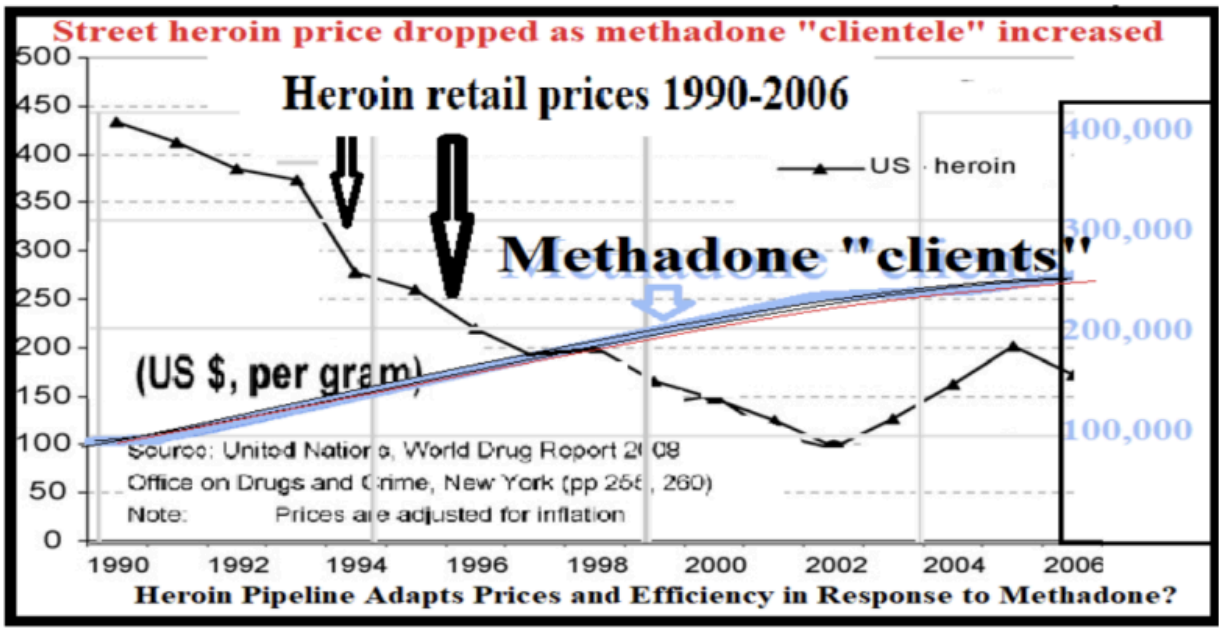
available narcotic prescription painkillers and methadone.





The illicit sale of "extras" of these prescriptions (known as "diversion") increases the street supply of narcotics and decreases the associated price, bringing about easier initiation to this

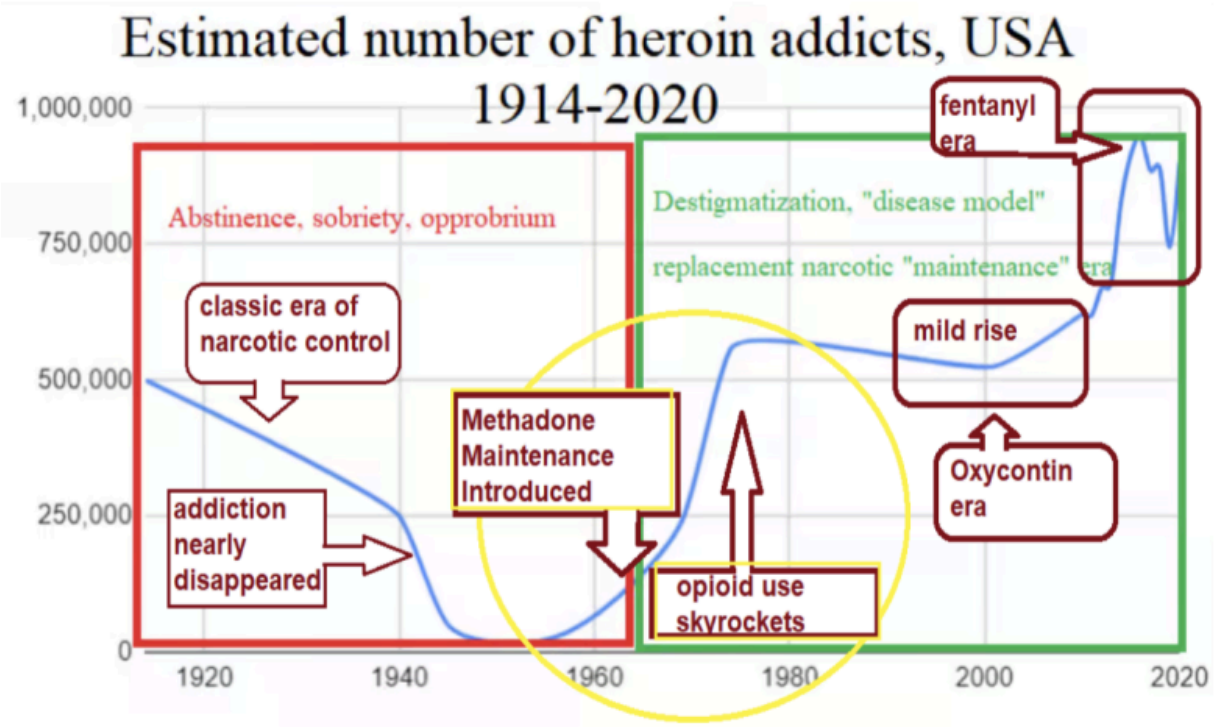
highly addictive class of drug.



The long-term maintenance strategy in current treatment of narcotic addicts additionally keeps the market for drugs alive, and anybody leaving such treatment abruptly has an immediate need for narcotic, with his habit not having decreased in potentially years of treatment. This is very much unlike the situation for alcoholics, who are alcohol-free between relapses.

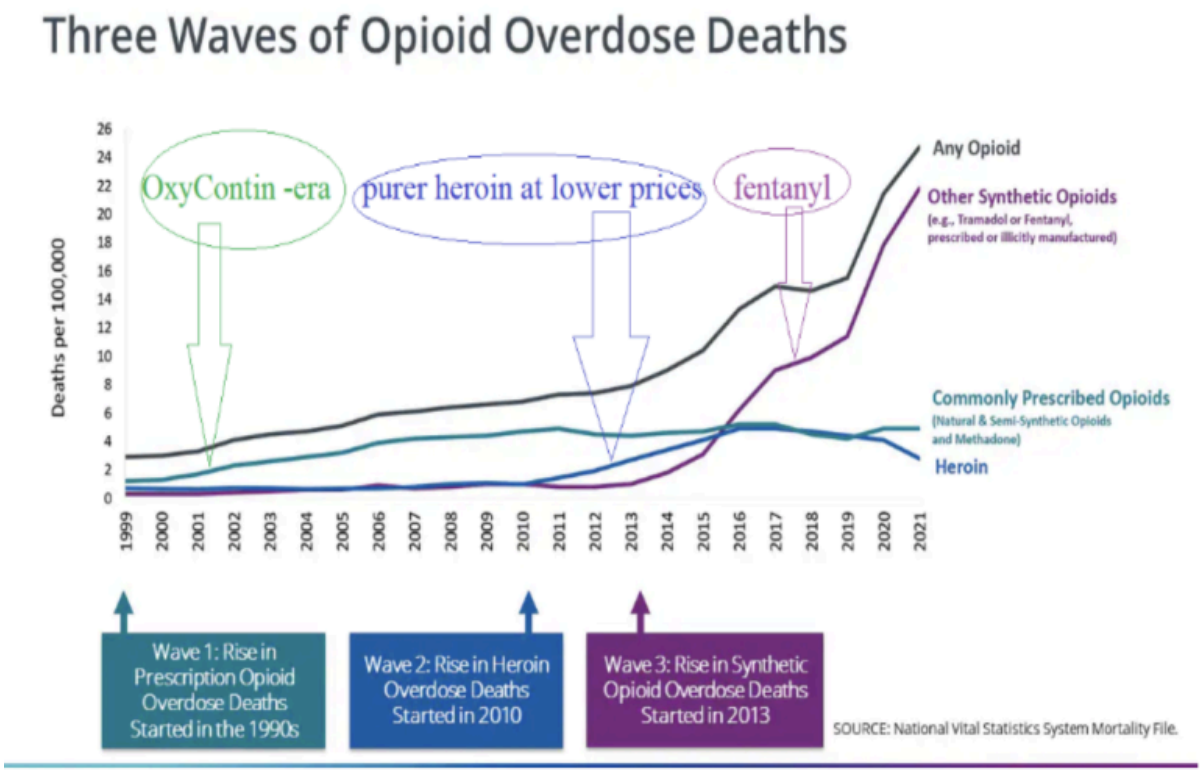
The stunningly enormous (about 600 percent) increases in opiate-usage these last few decades,[23] occurring coincident with economic and social upheavals, would overwhelmingly indicate these same cultural influences being the principal determinants of narcotic-use behavior, since the underlying demographics, the people themselves, haven't changed that much in the interim.

[23] "Understanding the Epidemic | Drug Overdose | CDC Injury ...." https://www.cdc.gov/drugoverdose/epidemic/index.html.



Any disease or syndrome that can increase six fold in a few decades almost (ipso facto) does not have a DNA-based prime-mover. In this figure, the CDC itself notes three different waves of the opioid epidemic: prescription opioids, heroin, and more recently fentanyl. Each of these has its own underlying motivators, none of which are genetic. The first wave is attributable to over-prescription of OxyContin; the second wave to addicts frugally moving during economic recession to the cheaper narcotic heroin; and more recently the mass importation of the super-potent fentanyl from China, via Mexican drug cartels, again a street-drug price-decrease impetus and rationale.[24]

[24] "Fentanyl has taken over America's drug market. Where is it ...." 17 Jun. 2018, https://www.sandiegouniontribune.com/news/public-safety/sd-me-fentanyl-pipeline-20180617-story.html.



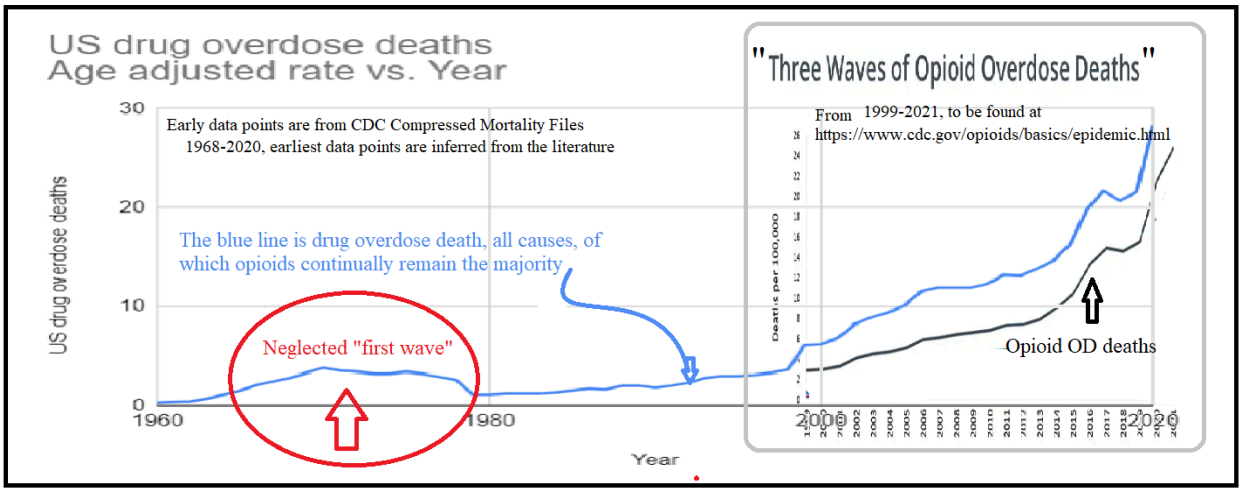
Nonetheless, the addiction treatment medical field continues to attribute about 50 percent of the underlying cause of opioid abuse to our genes, despite skyrocketing numbers.[25] Linking half of the cause of narcotic abuse literally to one's DNA implies no feasible eradication.

These determinations of genetic involvement are based on an underlying faulty premise:[26] that sets of fraternal twins have precisely the same upbringing as sets of identical twins.[27] In fact, "(identical twins) are treated more similarly by their parents and by the social environment, spend more time together, and share a closer emotional bond."[28]

Here is presented a slightly different view of the matter, so please consider this contrary argument carefully. For instance, all these characteristics associated with opioid abuse, listed below, show more in common with a behavior (say cigarette smoking or gambling) than with the standard diseases of aging (such as arthritis, diabetes, or hypertension), of infection (pneumonia), or pure genetics (cystic fibrosis). This is not to say that there is absolutely no genetic factor in

[25] "Genes and Addictions - NCBI." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2715956/.
[26] "Genetic and environmental influences on alcohol ... - PubMed." https://pubmed.ncbi.nlm.nih.gov/18519825/.
[27] "Twin Studies Help Define the Role of Genes in Vulnerability to ...." 1 Nov. 1999, https://archives.drugabuse.gov/news-events/nida-notes/1999/11/twin-studies-help-define-role-genes-in-vulnerability-to-drug-abuse.
[28] "Twin Studies in Psychiatry and Psychology - Jay Joseph." http://jayjoseph.net/yahoo_site_admin/assets/docs/Twin_2002_pdf.15583400.pdf.

determining opioid abuse, just that it does not seem to be the principal factor given the wide fluctuations in usage over the decades coincident with greater narcotic availability, lower narcotic prices, increased prescription painkillers, fentanyl importation, and the numerous unintended consequences of the partially beneficial "harm-reduction" approach, e.g. maintaining roughly 300,000 chronic methadone users[29]--all of them but one missed visit away from a returned narcotic habit, in full.



Okay, here they are.

Sex. Men are twice as likely to experience substance dependency as women.[30] Very similar ratios are seen, worldwide, for cigarette smoking, gambling, criminality, alcoholism, and other risk-taking activities—but not the common diseases.

Vast fluctuations in rates. Narcotic usage basically tracks as a "death from despair." Notably with an improving economy 2017-2020 (until the recent coronavirus), there was the first reversal in the opioid epidemic trend line of increasing deaths. Here's "heart of the epidemic" Allegheny County, Pennsylvania data. Notably the public health officials can't ascertain the reason for the drop, except for more readily available (overdose-antidote) naloxone[31]; however, naloxone usage went down as well.

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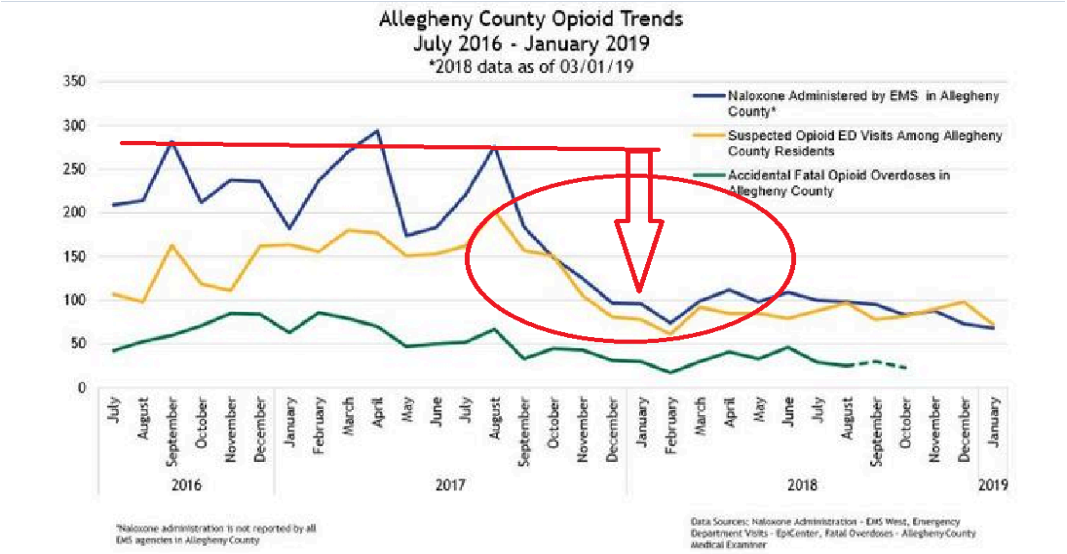
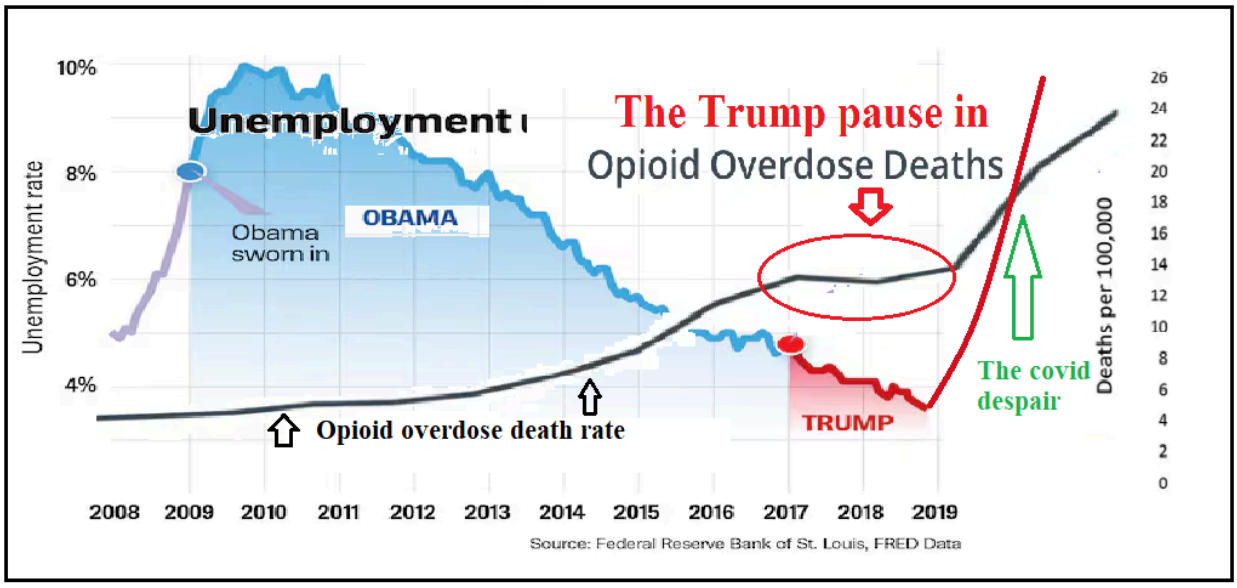
[29] "The N-SSATS Report: Trends in the Use of Methadone and ...." 23 Apr. 2013

[30] https://www.pewtrusts.org/en/research-and-analysis/articles/2019/06/03/men-more-likely-than-women-to-face-substance-use-disorders-and-mental-illness

[31] https://www.wesa.fm/post/opioid-deaths-allegheny-county-declined-last-year-though-public-officials-cant-say-why#stream/0



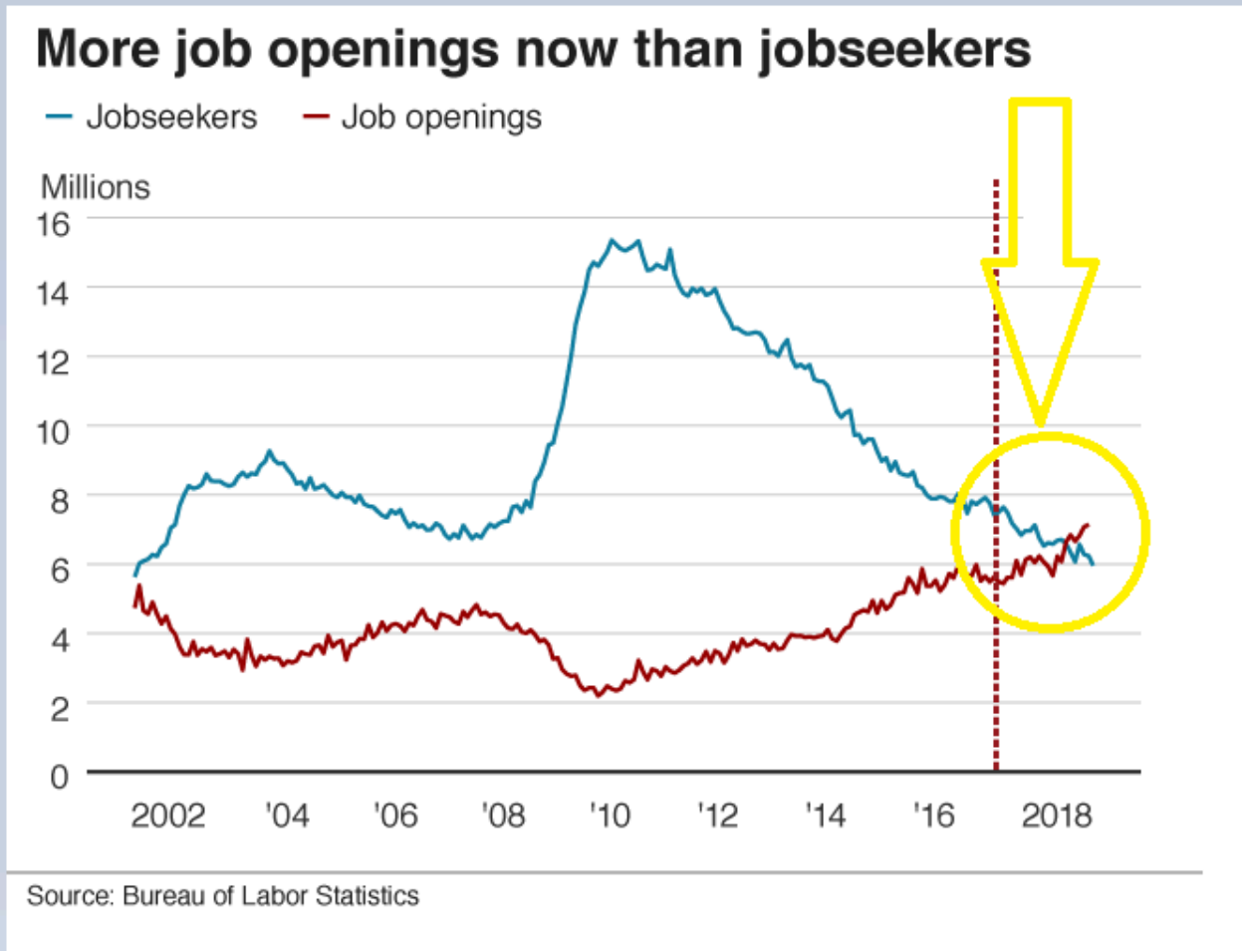
Deaths and narcotic usage declined when there was essentially more *hope of a complete life*: work, dedication, and possibility. No matter what your own political stand is, it's essentially inarguable that the 2016 election swung on just this, disaffection in the Midwest: Fifteen years of a vicious cycle of disappearing jobs, increasing drug use, being overlooked and forgotten, creating a condition breeding despair. In the last few years we've seen a reversal.[32]



Correlation can't confirm causation, but since narcotic usage seems to be predicated on mood,

[32] Update: Deaths Of Despair Declined In 2018 - Update: Deaths Of Despair Declined In 2018

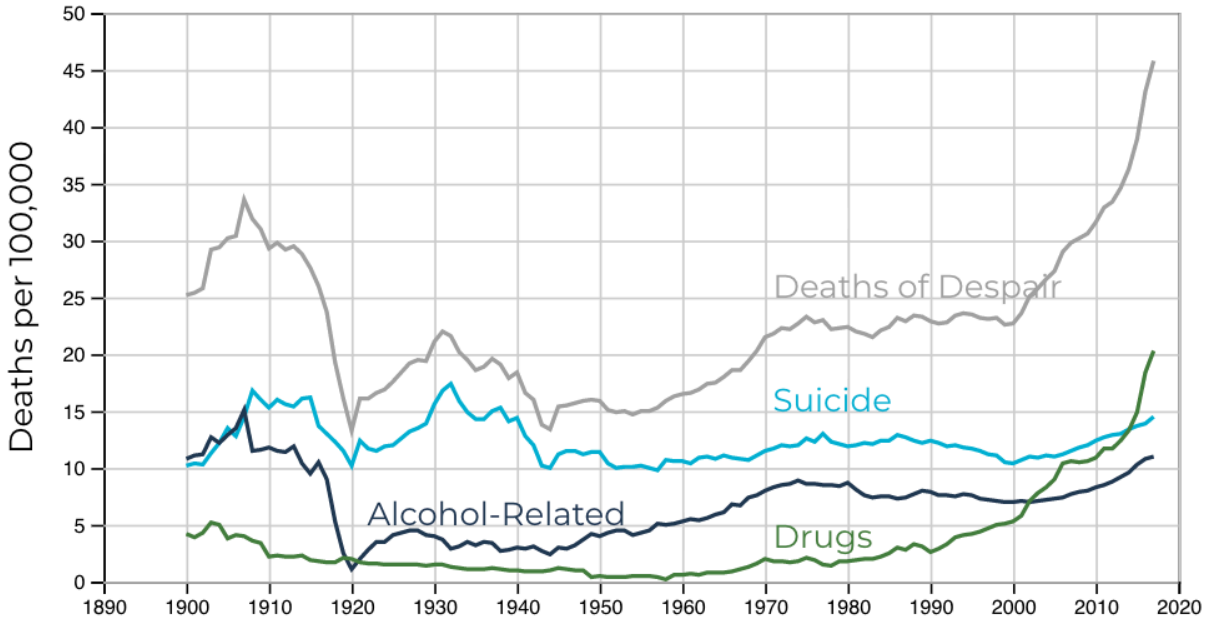
there is a presumption that people in better spirits have less need to escape or self-medicate. For the duration of the opioid epidemic, there have been huge undertakings such as expansions of narcotic treatment, introduction of buprenorphine, and public health measures including anti-overdose injection kits in ambulances. The biggest decline came not from any of these medical or public health measures, but economically and culturally. This is just one crude measure, but the decline in opioid usage and death coincides with domestic jobs being even more numerous than the workers seeking them.[33]



The principal conduit of the increase is drug deaths, principally opioid overdoses. The rate of narcotic-related deaths currently is more than 10 times greater than it was 1940-1960 (the green line).[34] Not a single disease's rate increased tenfold in this same time frame (outside of new

[33] https://www.bbc.com/news/business-46075879
[34] Long-Term Trends in Deaths of Despair https://www.jec.senate.gov/public/index.cfm/republicans/analysis?ID=B29A7E54-0E13-4C4D-83AA-6A49105F0F43#_edn1

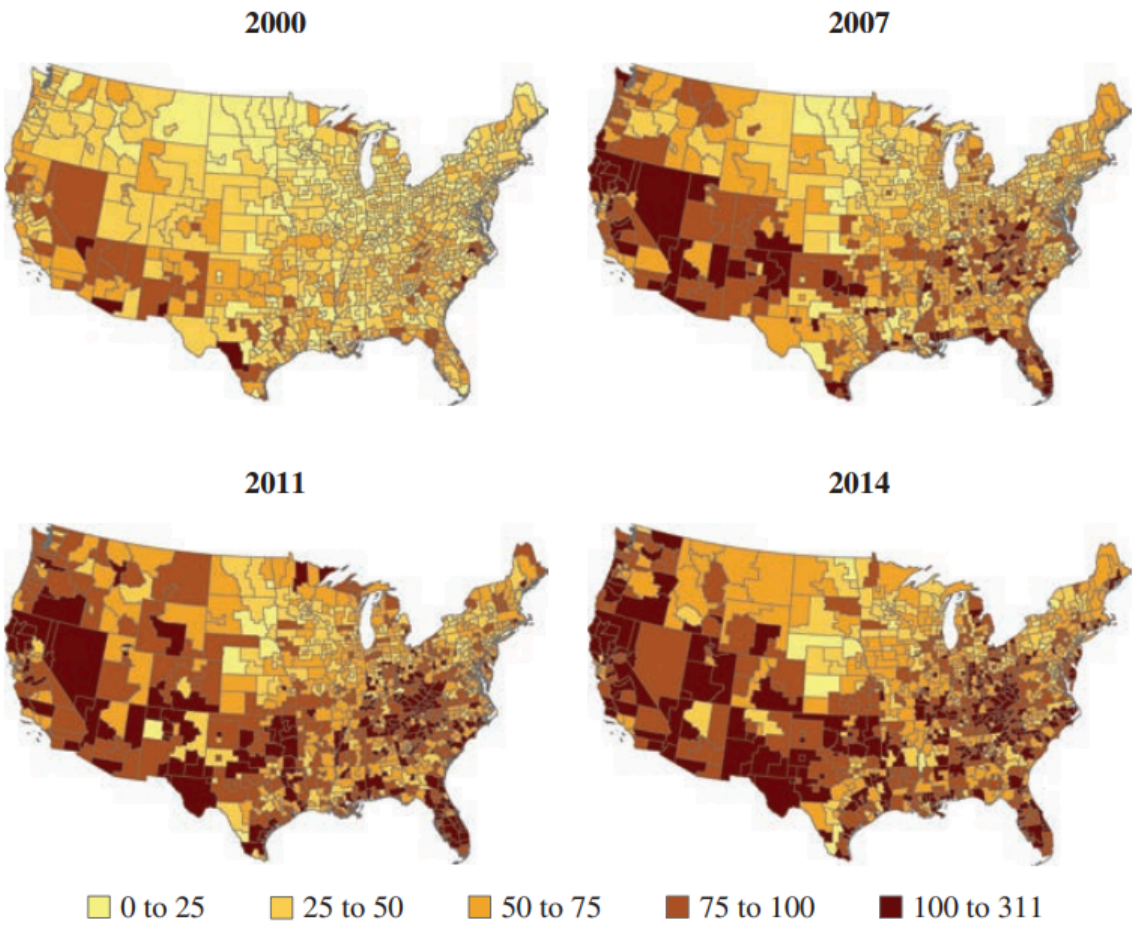
infections). Behaviors, activities, and habits have this type of variability; innate, unavoidable illnesses do not.



And these increases have occurred primarily in certain focal areas and amongst certain age groups and demographics: white, non-Hispanic middle-aged men in the non-coastal, less urban areas.[35] Genetics can't explain this demographic bunching because it didn't follow one specific ethnicity, it tracks more with geography and economics. Genetics does not explain the huge increases in numbers nor the more recent decline. Whatever genes these particular people have now, they had equally (as a demographic group) twenty and fifty years ago, with vastly lower drug numbers.

[35] Anne Case and Angus Deaton (2017). "Mortality and Morbidity in the 21st Century." Brookings Papers on Economic Activity. Spring 2017. https://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf

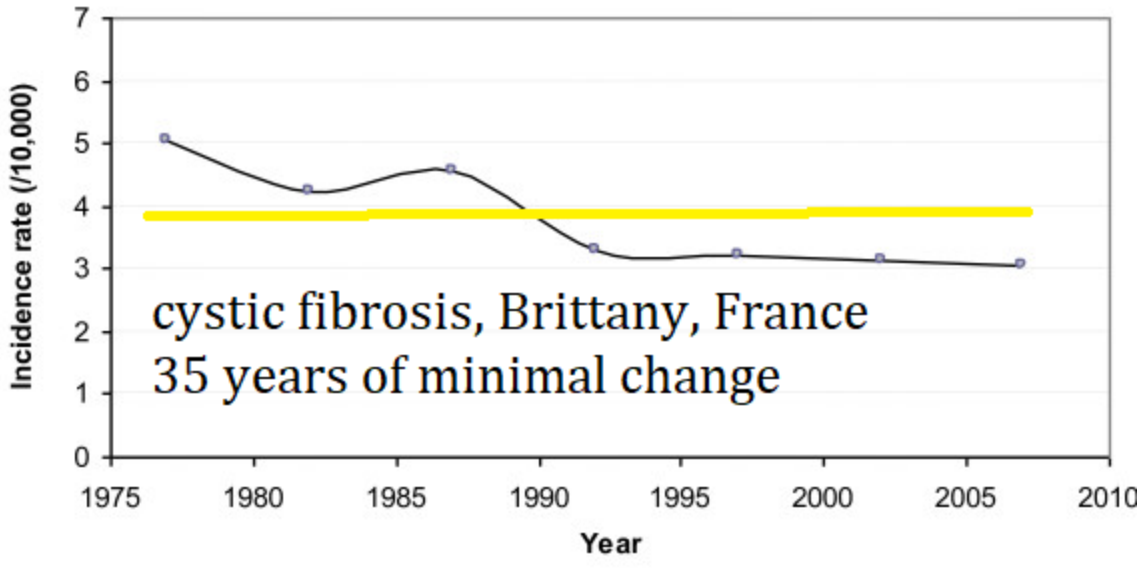
Figure 6. Deaths of Despair for White Non-Hispanics Age 45–54, by *Couma*, 2000–14[a]



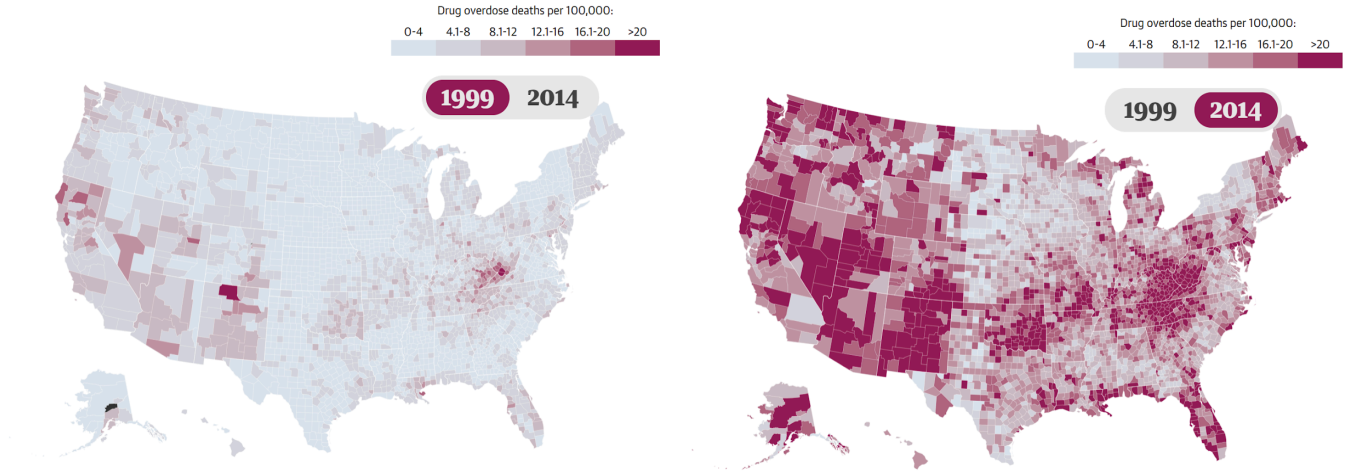
Sources: National Vital Statistics System; authors' calculations.
a. Deaths of despair refer to deaths by drugs, alcohol, or suicide. The units are deaths per 100,000. *Couma*s are geographic units that are a blend of counties and Public Use Microdata Areas.

For quick comparison, look at the multi-decade incidence-rate of cystic fibrosis, a pure genetic illness, whose rate would hold constant, but for recent prenatal testing[36] and birth-avoidance by abortion.[37]

[36] "Evidence for decline in the incidence of cystic ... - PubMed." https://pubmed.ncbi.nlm.nih.gov/22380742/.
[37] "Neonatal screening for cystic fibrosis in Brittany ... - The Lancet." 2 Sep. 2000, https://www.thelancet.com/journals/lancet/article/PIIS0140673600026520/fulltext.



Compare that relative stasis of disease-incidence to this incredible change in but 15 years in the United States.



"A deadly crisis: mapping the spread of America's drug overdose epidemic"
https://www.theguardian.com/society/ng-interactive/2016/may/25/opioid-epidemic-overdose-deaths-map

Beat-generation writer William Burroughs once phrased it[38]: ***"Addiction is a disease of exposure.*** *Doctors*[39] *and nurses, for instance, have a high addiction rate*[40]***."*** Exposing more of the country to more narcotics (including well-intentioned, prescribed methadone and Suboxone) has brought more narcotic addiction. [41]

Location supersedes ethnicity. Southeast Asia (e.g. Vietnam, Cambodia) has nearly the world's highest rate of narcotic usage, yet its U.S. immigrants are amongst the lowest of any US ethnic groups. Seemingly, the greater expectations and possibilities of career success made

[38] https://www.stopsmilingonline.com/story_detail.php?id=1268&page=2
[39] https://gme.med.ufl.edu/files/2014/02/Drug-Abuse-Among-Doctors.pdf
[40] https://americanaddictioncenters.org/rehab-guide/addiction-statistics-demographics/medical-professionals
[41] https://brownstone.org/articles/methadone-maintenance-ignited-americas-opioid-crisis/

possible by crossing the Pacific Ocean flip the off-switch in Vietnamese and Cambodians' opiate-usage. Genetic-makeup doesn't change, but behaviors do.

Age. With time, even those with chronic narcotic addiction self-cure. Prevalence peaks during the young adult years, and then wanes rapidly as people take on more responsibilities and learn and make better choices.

Class. Narcotic usage is more prevalent (ironically) amongst those with the fewest finances to support it,[42] perhaps indicating that society's strongest "anti-drugs" are its general success correlates: educational achievement, family cohesion, continued employment, community involvement, and faith.

Religion. Faith plays a profound role in both preventing and reducing narcotic addiction. For instance, practicing Mormons have significantly lower rates of adolescent drug use [43] than surrounding populations, despite being genetically indistinguishable from their neighbors. Furthermore, studies show that within the same ethnic group, individuals who attend religious services more frequently are less likely to struggle with addiction.[44] Behavioral recovery programs like Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) also rely heavily on spirituality and the concept of a higher power, underscoring faith's pivotal role in curative efforts. Interestingly, few other diseases show such striking preventive and curative benefits from religiosity.

Nonetheless, the disease theory of addiction has gained dominance within the medical establishment, championed by organizations like the American Medical Association (AMA), the National Institute on Drug Abuse (NIDA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). The AMA officially recognized addiction as a disease in 1987, describing it as a chronic condition requiring medical intervention. NIDA has consistently defined addiction as a "chronic, relapsing brain disease"[45] characterized by compulsive drug use despite harmful consequences, with its approach heavily influenced by Nora Volkow's research on the neurological basis of addiction. SAMHSA similarly frames addiction as a disorder of brain circuits, with its prevention and treatment programs based on this model. While this

[42] https://aspe.hhs.gov/system/files/pdf/259261/ASPEEconomicOpportunityOpioidCrisis.pdf
[43] Contemporary Mormonism Social Science Perspectives Edited by Marie Cornwall, Tim B. Heaton, and Lawrence A. Young 2001

[44] https://www.ojp.gov/ncjrs/virtual-library/abstracts/religiosity-spirituality-and-substance-abuse
[45] https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction?utm_source=chatgpt.com

framework underscores addiction's biological underpinnings, it often downplays the role of personal choice and environmental factors, which are critical components of the behavioral model.

This labeling of addiction as a "disease," with its implication for lifelong care or supervision, serves the purposes of treatment professionals but perhaps not of patients. In a simple, personal sense, seeing addiction as disease frees users to blame a poorly understood and unforeseen cause, rather than our better-known and universal human characteristic: fallibility. The disease theory renders addicts needlessly helpless to mobilize against their own choices, short-circuiting the necessary counterforces ordinarily mustered in solving concrete, identifiable problems.

Leaving addiction aside for a moment, how would these two different approaches, as applied to a non-addiction related problem, work out?

Consider this scenario.

You awake, startled, having heard a noise in the house. You must quickly decide what caused that noise. At different times, people might have thought such a noise could emanate from spirits, ghosts, or other denizens of the uncontrollable supernatural, and then shiver in fear and await the consequences. On the other hand, let's presume the noise comes from a real source: a squirrel or a mouse; the radiator; an open door; an intruder; or even a relative's footsteps on the way to the lavatory. These are concrete, identifiable problems.

Either way, a decision about how to proceed must be made: take action or wait and see.

Let's say, for argument's sake, that it's a 50-50 proposition. One theory is supernatural, the other real; one uncontrollable, the other fixable. Deciding the cause is out of your control (such as with disease theory) severely limits any constructive reaction. Conversely, deciding that there is a real, tangible cause inevitably leads one to create a plan of attack to conquer the problem, with admittedly very different plans if it's a mouse versus a human intruder.

Which method would you choose to pursue? Those who start under the presumption it's a conquerable problem have a clear head start on a solution over those who take the opposite approach. More significantly, even if the problem is genuinely outside the realm of personal control, no harm ensued in having first developed a strategy for the opposite scenario. From a game theory point of view, the overall winners are those who actively make plans against a conquerable foe, versus those who presume, from the start, that there is no defensible strategy and choose to do nothing.

Along these lines, this book asserts that users of narcotics *can* navigate (perhaps while needing some help and guidance) their way out of the addiction maze. Even if this is wrong, the necessary mobilization inherent in devising a strategy leaves the more active planners better armed for future travails than the more passive.

That is not to say that there are not reasonable points to be made in favor of the disease argument:

- Addicted people feel "sick" every morning,
- Look for relief in treatment,
- Have relapses, and
- Feel tired, depressed, and worn out.

However, addiction's causing undeniable physical misery and interpersonal damage does not, by itself, imply any one particular root cause of, or solution to, the problem. Many other people not using narcotics, such as gamblers, divorcing couples, and prisoners, experience similar sensations and consequences without needing to wonder about any deeper cause than the events themselves. For example, pregnant women experience symptoms that mimic illness, but few would call pregnancy a disease or wonder about its cause.

A Deeper Understanding

Understanding the cause of a problem is crucial to its eradication. In the 1960s, my grandfather suffered from peptic ulcers. The medical approach to ulcers, at that time, was nearly opposite to today's addiction-as-disease debate. Currently, we call the likely behavioral choice of addiction a disease; whereas, with ulcers, it was thought that what we now know as a disease was a behavior: blaming stress and recommending behavioral changes, such as relaxation, for treatment.

Science has since rescued ulcer-sufferers, brilliantly discovering bacteria's role in this condition. Antibiotics, in two weeks' time, eliminate ulcers such as my grandfather's, which afflicted him for decades despite his bland diet and avoiding undue stress. Science's similar successes against numerous, previously unsolvable maladies have perhaps generated societal

overconfidence of a definitive, discernible, discoverable reason for *every* problem.

The seemingly logical move would be to categorize addiction as a disease: then, *voilà*, a cure! But addiction is not as focal and local a problem as ulcers; similarly, merely noticing MRI-patterns of possible and non-specific "brain changes" is not the same as isolating a living, burrowing bacterium and then proving its disease role. The bacterium's elimination yields a 100 percent cure rate, while labeling narcotic addiction a "disease" has (if anything) *increased* its incidence and certainly has not come close to eliminating it.

There is no evidence to suggest that addiction is likely to have as simple a cause as a bacterial infection. While there is a fair understanding of neuronal impulses on a cellular level within the brain, there is less precision in understanding how all these impulses interact in creating the miracle of a single thought, let alone patterns of behavior. This is not surprising, and the same holds true with other systems. Think of the weather, for instance. We can understand how an ice crystal forms, how water evaporates, and how wind moves, but we have a much harder time predicting their combined effect in determining weather as a whole.

Now try to work this problem backwards. Imagine the difficulties that would ensue if we had to figure out the nature of ice crystals knowing only weather patterns. So it is with trying to assert a brain disease from looking at brain imaging, which is basically a "weather map" of the brain.

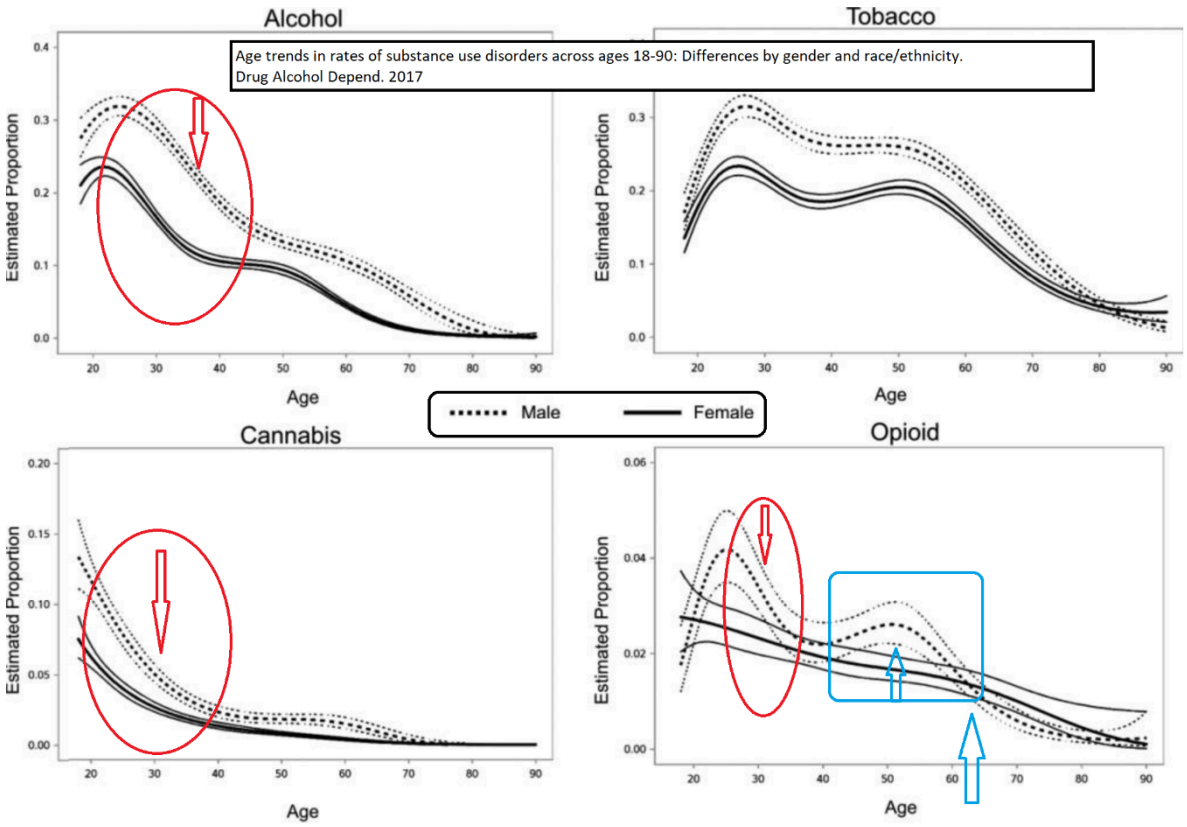
There is also an issue of how data are used, often as foot soldiers in a larger battle and often contrary to common sense. No attempt is made here to minimize the extent of the addiction problem noted in the AMA's position paper,[46] but the referenced brain changes are not specific to addiction nor decisive in determining its cause. Case in point, observable brain changes occur with many non-disease emotional changes, such as falling in love[47] and ending a relationship.

Focusing on these fascinating, but possibly inconsequential, scientific observations diverts attention from the larger context—the bigger picture that we intuit with common sense: most jams we work our way into, we can work our way out of. Nearly everyone recognizes that most of our country's drug abuse problem is concentrated in the population aged from teenage years to the early thirties, with rates falling off substantially by the mid-thirties as people gain maturity, experience, and responsibility. This pattern holds true for substances like alcohol, cocaine,

[46] https://nacchocommunique.files.wordpress.com/2017/08/harmful-substance-use-dependence-and-behavioural-addiction-addiction-2017-ama-position-statement.pdf

[47] https://hms.harvard.edu/news-events/publications-archive/brain/love-brain

amphetamines, and marijuana, which typically decline in use as individuals grow older and make life choices aligned with stability and accountability.

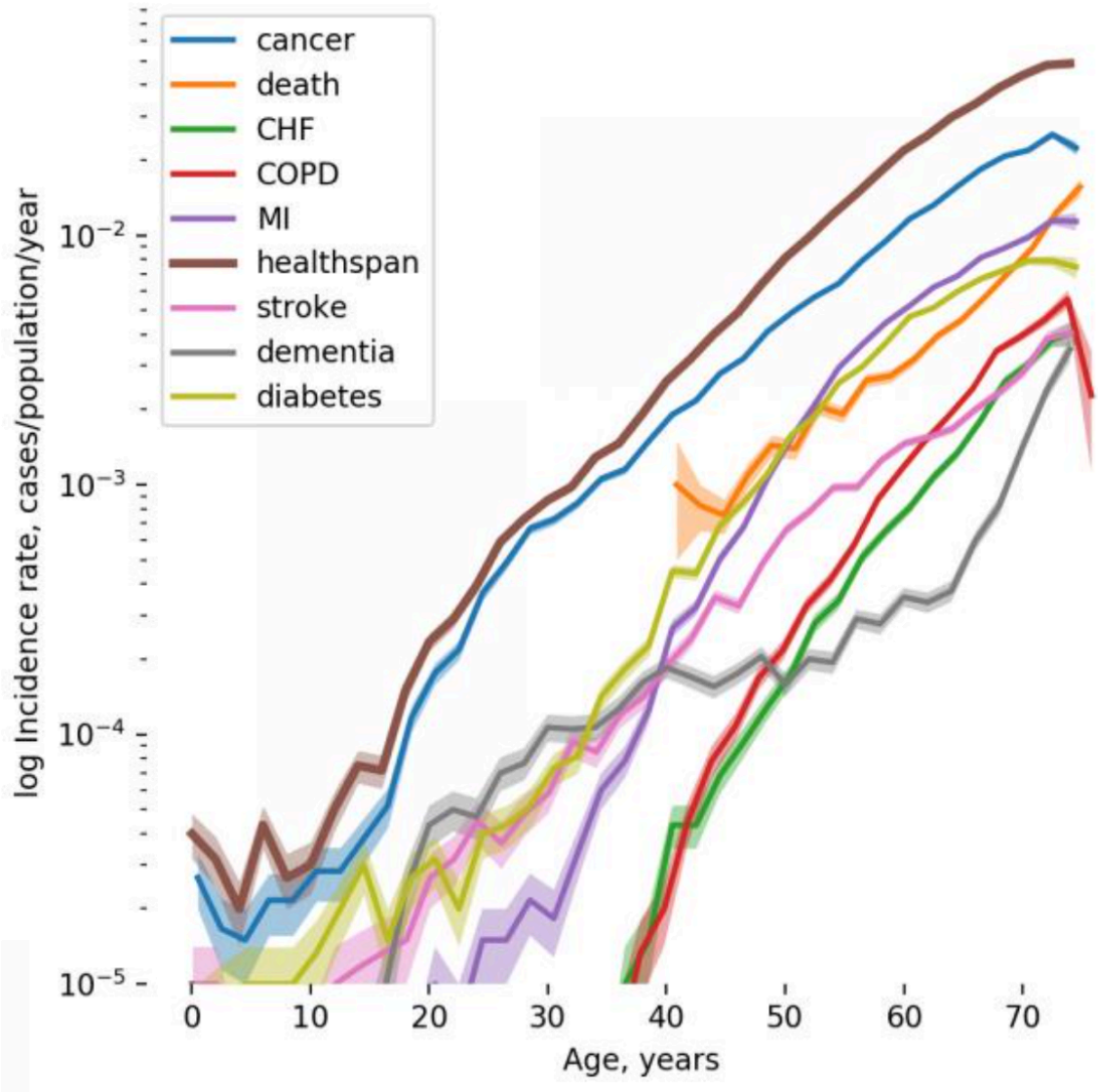


"One of these is not like the other"; mood altering drug use decreases with early adulthood advances, 20-40 – EXCEPT grows again ONLY for opioids which is the only one here that has "MAINTENANCE" replacement drugs, i.e. Suboxone, methadone and medicalized "disease model" of continued treatment through essentially lifelong.

However, opioids stand out as an exception, creating what might be described as a "two-hump camel" effect. Usage decreases from the chaotic years of youth into early middle age, much like other substances, but then plateaus and even slightly rises again among older adults. This second hump reflects the impact of the medicalized “disease model” of addiction, which has introduced systemic encouragement to maintain dependency through programs like methadone and Suboxone. These interventions, while initially intended to reduce harm, often sidestep the opportunity for individuals to confront and overcome their problems through life experience and maturity. Instead, they provide a kind of "wind under the sails" of dependency, cushioning the consequences and perpetuating use.

In contrast to substances like alcohol or cocaine, where no parallel system exists to normalize indefinite maintenance, opioids have been uniquely shaped by a framework that prioritizes

stabilization over recovery (to sobriety) . The result is an artificial extension of dependency that defies the natural decline observed in other substances as individuals grow older. This is key. It is well known that *diseases* (heart attacks, strokes, renal failure, diabetes, cancer, etc.) become more *common and/or more severe with age*.[48]



Addictions and behaviors form a distinctly different and opposite trend: markedly decreasing, nearly to zero, in prevalence, as people age—although these data will change if the current trend of locking-in long-term, narcotic replacement maintenance treatments continues to extend

[48] https://www.eurekalert.org/news-releases/856453

addictions of the young to addictions of the middle-aged and then elderly; at that point the disease-model will have become a self-fulfilling prophecy!

Father Time's "secret agents," maturity and wisdom, win the battle against addiction and behaviors nearly every time, but have no ability to slow down any long-term disease's relentless deterioration and damage.

If addiction is a disease, it is perhaps the only one helped by merely aging!

The concept of *common sense*, by this chapter's end, will have been mentioned a few times, so its meaning should be clarified: sound judgment, good sense, and knowledge held by people "in common" based on their own experiences more than those of experts or researchers. In other words, people's belief in what they see with their own eyes, hear with their own ears, and experience in otherwise sensory, tangible ways. Common sense gets us safely across busy intersections, through tense confrontations, and back home every night; yet, in the formation of our opinions, is often not a match for fresh, gleaming "science" at its most daunting, presented in the intimidating authority of experts.

Common sense might be getting short-sold here because expert opinions suffer from being over-particular. The parable of the seven blind men is pertinent. Encountering for the first time an elephant, each feels one distinct part (an ear, the tusk, the tail, a leg) and comes away with his own valid, but mutually contradictory, opinion of what an elephant is. A commonsense assimilation of their opinions yields, more accurately, the holistic, genuine article in comparison to each individual's scientifically obtained, rock-solid observation.

This is understandable, given the scientific basis of the incredible technological advances improving and streamlining our lives; however, as we observed in the case of weather, science has a harder time fully explaining systems as they get more complicated. Scientific explanation of planetary motion accurately predicts a sunrise time whether two days or twenty years hence, but not the weather, the news, or our moods on that day (or any, for that matter). Scientific observation can monitor our desires and wishes relative to each other economically (expressed as prices and sales) but can't predict tomorrow's stock market prices, individually or collectively. In short, science more closely approximates verifiable natural law the more we can zoom in with our microscope or telescope: atomic particles, cellular processes, or dense stars in otherwise empty space. However, as the viewfinder becomes overpopulated with objects and processes, science fades as a predictor.

Common sense, informed by repeated observation of a phenomenon over time, therefore, becomes a stronger player than science; hence, the larger the playing field, the more complicated the situation. Peyton Manning or Tom Brady (and now Lamar Jackson, Patrick Mahomes, Josh Allen) intuitively read a defense better than cameras. Mega-investor Warren Buffet's down-home business acumen and common sense have outperformed more scientific, computer-aided modeling algorithms in the vagaries of the stock market. The key with use of science in larger systems is not to assume that it is fully predictive and not to assume that some scientific items are not being put to use in service of a larger agenda. This happens so often in the fields of economics and politics that most people have tuned out the various studies that one side or the other will use to push an argument.

Brain Changes Do Not Indicate Disease

This chapter's disease versus behavioral theory of addiction discussion began by noting the AMA's endorsement of disease theory, referencing the scientifically observed brain changes that take away a person's self-control. Does that mean that the acknowledged voluntary starting (and addictive continuing) of narcotics is a complete one-way, no-exit, dead-end street? Are those very same people who voluntarily began drugs eternally unable thereafter to return to their pre-drugged life's willpower and decision-making? I think not. These scientifically observed brain changes are often interpreted as irrevocable, like permanent stains, rather than injuries from which one can recover. Even in the absence of any addictions, the brain is always changing with our moods, with age, with differing experiences. The brain "hung over" from alcohol, drugged, or in withdrawal is certainly not at its best, but a little bit like the weather, just wait: it will improve.

Even persistent drug use doesn't change the brain permanently. The fact that as people get older they generally steer away from narcotics implies the opposite: that they have learned life's lessons. From experience, we all have advice we could give to our younger selves. So too it is with narcotic addicts: they make certain more impulsive choices early on; are generally more cautionary in middle age; and more likely sober when elderly. Never should they be written off as unable to make better decisions and choices.

Brain changes have been found in morbidly obese individuals.[49] It's been said that these changes towards impulsivity prevent losing weight and keep people on a certain track to remain obese. The TV show *The Biggest Loser* demonstrated that anybody, when given enough encouragement, can lose weight. Whether the weight stays off is certainly another question, but certainly it will never come off unless people try. Nobody recommends "maintenance" for obesity. Even those who may not succeed should try, and try their hardest and receive our encouragement.

People in general, and people addicted to drugs, or beholden to narcotic replacement treatments particularly, will shy away from challenging scientifically observed brain changes. These findings are not easily understood by the average person, and perhaps they should be. Might people be more likely to see brain changes as reversible if they were at the same time informed that brain changes are present when we fall in love?

I wonder if the AMA will endorse calling love a disease as well? Should they choose to do so, they could refer as far back as Dr. John Ford Barbour's 1894 article, "Is Love a Disease?"[50] published in the *Journal of Nervous & Mental Disease,* which noted a number of physical signs coinciding with the "disease of love." I've included our modern day translations below, in parentheses.

- "A gentle languor pervades the frame." (Lack of physical or mental energy, fatigue.).
- "The respiration becomes sighing." (Shortness of breath.)
- "There is a tendency to suffuse the countenance at the mere sight or mention of the object of predilection." (Facial flushing, i.e. blushing, when thinking of the loved one.)
- "Accompanying this is a great confusion of thought and language, probably caused by the same nervous disturbance that induces the suffusion of countenance." (An inability to express oneself.)
- "There is insomnia and a loss of appetite." (No translation needed here.)
- "Sometimes they are careless of their persons and estates." (People lose track of their appearances and finances.)

This charming article, seemingly written tongue-in-cheek, notes that people "will wonder at their own folly, madness, stupidity, blindness," a result of their having been deeply in love, once

[49] "Brain Structural Differences between Normal and Obese ...." 16 Jan. 2017,
[50] https://journals.lww.com/jonmd/Citation/1894/06000/Is_Love_A_Disease_.4.aspx

the most intense period is over. The good doctor believes that "a severe attack of the acute variety generally grants exemption from subsequent attacks"—that is to say, "people who fall too hard in love the first time are more careful on the next."

If love can have been seen bringing on, much like a disease, symptoms of "fatigue, shortness of breath, flushing, confusion, loss of appetite, lack of sleep, and personal neglect," back in 1894 (and, truth be told, for ages before that), we hardly need 21st-century science's 'brain changes" to seal the deal. In reality, love won't be determined to be a disease simply because there happen to be brain changes; conversely brain changes should not determine disease status of other conditions, particularly those, such as addiction, that include so many of the same emotionally based symptoms.

Even a jump on the "determination by science" bandwagon would not seal the deal, because falling *out* of love brings on brain changes as well. As noted in the aptly named article "Losing Love Has Similarities to Addiction,"[51] researchers looking at the brains of the lovelorn say, "rejection by a romantic partner lights up areas of the brain that are associated with addiction, reward, craving, and depression." The subheading of the title, "Aftermath to a Romantic Breakup is Marked by Withdrawal, Relapse, and Cravings," could well be a talking point in the AMA's position paper (if the words "Romantic Breakup" were replaced with "Narcotic Usage").

Since most of us fall in love, and, later, may fall out of it, the argument of brain changes causing permanency fails as well. The fact that brain changes occur during a narcotic-soaked, emotionally tumultuous addiction phase should not sway the disease argument one way or the other. Additionally, the fact that such brain changes do occur during the advent of an addiction does not imply that the brain can't change back to its original status or in fact change to some new situation that replicates neither the addiction phase nor the pre-addiction phase. It is said (debatably) that "you can't teach an old dog new tricks"; well, our brains are not old dogs. Obviously, brains do age, along with the rest of our bodies, and with age, it is harder to make changes to certain ingrained habits; however, nearly the gamut of human experience shows that we are capable of learning and making changes, with intention. Merely holding and reading a book such as this implies that you, the reader, agree with the concept of the human gift of learning and adapting with greater knowledge and experience.

At the end of the day (or at the end of this debate), those seeking treatment for narcotic

[51] https://www.webmd.com/sex-relationships/news/20100709/losing-love-has-similarities-to-addiction#1

addiction don't need to have a firm and fixed opinion on either side of this behavior-versus-disease question. No uniformity or orthodoxy of opinion on this matter should be enforced as part of the clinical experience. The fact of the matter is that these days, almost every encounter with professional drug treatment entails reinforcement of the disease theory. Nearly every patient in our sample who has undergone treatment initially posits that "addiction is a disease," while referencing previous drug clinics' counseling/teaching-sessions' reinforcement, rather than their own assessments or feelings on the subject, which are split closer to fifty-fifty.

Not every question yields a definitive answer. We ask, "Is there a God? Are we alone in the universe? Can there be a world without war? Who should control the remote? Does hope spring eternal?" Even those questions that *seem* to have an answer can be flipped around on given days. A sports car owner can have regrets while sliding on the roads during a blizzard, especially when passed by a sturdy SUV—who alternately may have regrets over his or her drab-looking vehicle. So it should be with this one question so central to the speed and purpose with which one can exit addiction.

The overriding take-home messages are these:

1. Despite the near unanimity of thought within the treatment world, and despite the presentation of its essentially being a closed matter in favor of disease, the disease vs. behavior question is far from settled. Most associated social trends regarding addiction are more closely allied with behaviors than with any specific disease trait.

2. The intense initial pleasure of narcotic usage can temporarily overwhelm more generally successful life behaviors; yet the ability of humans to learn and adapt is unrivaled in the animal kingdom. Understanding the need to apply personal resources and resolve, as well as attention and devotion, will help sooner to bring about the self-preservation instinct. Maturity, wisdom, and experience come after struggle, but may not come at all if poor personal choices are recast as immutable diseases.

As goes the saying, it is better to have loved and lost than never to have loved at all. So too, knowledge of the possibility of relapse should not keep one from getting clean.

Part 2: The Bock Method

This part of the book outlines the Bock Method of withdrawing to freedom, which is focused on helping you choose a doctor who supports your goal to live a life *completely* free of substances. First, though, I want to help you understand the different options that exist in terms of treatment programs, as this will play a role in the selection of doctors available to you.

6. Getting Started

Addictions are difficult. The motivations are multiple, the courses differ, and people are unique. So it's no surprise that addiction treatment itself is complex, but perhaps it does not have to be as daunting or overwhelming as sometimes it seems. Part of that comes from its hidden aspect.

We hope to correct at least part of this by discussing the options out there, and how to think about them. Although almost all initial treatment is called "detox," this phase doesn't always actually "detoxify" in the sense of completely removing the drug from the narcotic addict's bloodstream. Some replace the street-procured opiate with a treatment opiate. Others use tranquilizers and other medications to smooth out withdrawal symptoms.

Only a few "detoxes" involve withdrawal to sobriety; many more intend a next step of replacement opiates. Understanding that the drugs and medications are only one part of recovery, and not necessarily the most important part), we will, nonetheless, examine this initial phase of treatment called "detoxification" and then move on to a discussion about the deeper, necessary work of full recovery.

Detoxification

Although the term "detoxification," or "detox," is widely used and has become accepted jargon in the field of substance abuse treatment, it's important to note its inaccuracy. The term implies a removal of toxins from the body, but narcotics are not, in fact, toxins. They are drugs essentially designed to mimic our naturally occurring endorphins, which are the brain's "pleasure neurotransmitters," and it is their success at doing so, not their supposed toxicity, that makes them so dangerous.

An endorphin is a natural brain signal that helps us feel good.

Morphine, a chemical imposter, affects the emotional state by mimicing the brain's natural endorphins.

Morphine and all of its chemical cousins including OxyContin, heroin, fentanyl, codeine, Suboxone, and methadone, work precisely because they are near-duplicates chemically and structurally to the neuropeptide endorphins that spark our various sensations and perceptions of pleasure.

As implied by the title of this book, the term "withdrawal" is not only a more accurate term to describe the purging of narcotics from the body, but also a more complete concept, suggestive of the comprehensive process involved with recovery. Nonetheless, because so many commercial programs consider themselves "detox programs," I will refer to them as such. Most such programs, however, do not encourage people to withdraw to full sobriety, believing that the pain of withdrawal may cause urges to return to street drugs. Thus, the effort towards sobriety is postponed or avoided entirely.

Beneficially, therapy and counseling begin soon after at these early stages. Attendance is reinforced behaviorally. Returning for visits, staying in treatment, will be rewarded with a replacement opiate, Suboxone or methadone. Any missed visit and resulting absence of a dose or a prescription yields the quick return of withdrawal symptoms. Maintenance patients have essentially the same, old narcotic habit, but without the struggles on the street to get a dose, which is provided, for now, medically. Suboxone may not give the same amount of a high, but straying from the clinic routine will prompt a return to scavenging and hustling very quickly.

Becoming fully sober is more of an investment physically and emotionally, but it yields the disappearance of the physiologic habit as well as the immediate need for more narcotic if for some reason a clinic visit is skipped. There is also the greater satisfaction of doing something for yourself rather than having something done for you.

Taking opiates for the very first time provides the recipient exquisite pleasure, but in a sense it's like borrowing money. You get the fun early on. Paying it back is much less enjoyable. Withdrawal to sobriety involves paying back that unearned opiate pleasure with discomfort, a process which can be fairly mild if done gradually. The maintenance programs ignore and postpone dealing with the body's drug-debt. It's almost like paying interest-only on that loan.

The Crucial Decision: Deciding on a Treatment Program

Once you are motivated to overcome addiction, the next step is considering the various options available for detoxification and subsequent treatment. Ask yourself these questions:

- What is the best program duration: short-term, medium-term, or long-term?
- Should the treatment be received in an in-patient or out-patient setting?
- Should the treatment be methadone- or Suboxone-oriented?
- What are the direct and indirect costs involved with various programs?
- Does your insurance support a particular program? If so, do you want to have your treatment known and covered?
- How will you manage work and family responsibilities while undergoing treatment?
- Keep in mind *you do not need to have all the answers to get started with your recovery.*

They simply represent a starting point to keep you focused on moving forward.

Detoxification: The First Steps

The first step of detoxification is of course realizing you need detoxification. People like winning, they like happiness, they like succeeding, and they don't like pointing out their failures to others, or having those failures pointed out by others, to them. The daily grind and misery of having to hustle for drugs, the incomplete and frustrated feelings of feeling sick without a drug are daily warning signs; but for many it's hundreds of days of dissatisfaction that proceed any decision to detox. Oftentimes there is some major event that occurs, maybe an arrest, or maybe a loss like a job, home, custody, or relationship. Announcing or accepting that one has failed and that one needs fixing is not always easy.

Perhaps this acknowledgment can be made easier by reiterating that we all fail at times. We've all had our disappointments, our reckonings. Humans are fallen creatures. We seek

redemption, we deserve forgiveness. The pathway to a narcotic addiction is human: trying to cover pains and insecurities with an immediate soft pleasure that perhaps, with jealousy, we see others getting, but not ourselves. It could be the drug was a way of "fitting in." It felt good, really good, and brought more pleasure than anything else going on at the time.

1. Resolve to stay clean. The initial commitment to stay clean needs to be reasserted as often as possible—in your head, in writing, out loud, however you can do it. Make the promise to yourself and people you trust, for accountability. Make positive assertions and follow through with a visit to your counselor or doctor. Sending positive thoughts to the mind is like feeding a nutritionally packed meal to your body. Think about when you were drug-free. You may not have been gloriously happy every day, but it's unlikely you were anywhere near as miserable as you are while on drugs. Remember that the human body is quite resilient, and things will get back to normal when you allow them to.

2. Understand the discomfort and acknowledge it is temporary. It is important to understand that while in withdrawal, discomfort is guaranteed; but it is only short-lived and typically not as severe as many will tell you. Do not allow your decisions to be colored by what is essentially momentary (in the grand scheme of things) discomfort (over days to weeks). It is a small price to pay to get your life back on track. Certainly, willingly enduring discomfort is a difficult proposition, but if getting off drugs were easy, there would be no drug addicts. When detoxification symptoms begin to occur, returning to drugs will be tempting, but remember your mind's strength can absolutely conquer your body's weakness. Revel in the satisfaction that you have started the transition to a healthy, happy, and drug-free life.

3. Understand the triggers. Even after detoxification helps rid your body of the abused substance, circumstances or triggers can lead you back to addiction. Certain behaviors, including illegal activities, indolence, selfishness, and drug-related friendships adopted during narcotic usage, must be abandoned. Fighting the triggers involves leaving your previous comfort zone.

4. Understand the financials. Different programs will involve varied levels of expenses. The cost of treatment to the addict or family can run from literally nothing (with a Medicaid card) to downright outrageous (at "money does not matter" private facilities, where the costs may be as high as $65,000 per month). Each of these extremes can have issues. Some twenty-five-year-olds have literally been in more than fifty detoxes, all "free" through Medicaid. Freely they admit they weren't necessarily paying attention while not paying out-of-pocket, their own funds. The

same might very well be true at the very expensive clinics, with the addicts still not personally paying, but having the costs picked up by family. Ideally one does not let costs determine path, but in the real world often it does. Some of the cost of treatment is not merely in the out-of-pocket expense, but the money that doesn't reach your pocket in the first place. Inpatient treatment is not only more expensive to pay for, but even more costly because there's no possibility of employment in the meanwhile. Outpatient programs have a higher likelihood of not interrupting work.

If you have private health insurance, do not take coverage for rehabilitation for granted. Contact your insurance company to find out how much you are entitled to, as well as the detoxification centers and private clinics they work with.

In case no insurance is available, you are left with two options: funding your own treatment or attempting to obtain free care or governmental benefits.

There is one significant benefit to paying for your own treatment: you are likely to be highly motivated to succeed. My experience is that people who are paying out of their own pocket are more serious about the timeline for getting clean and stick to their goals more consistently. Think about it. If your insurance company is footing the bill, leaving you with no financial responsibility or perhaps just a $20 or $30 copay per session, it simply doesn't "hurt" as much to falter in your commitment.

This is not to say that you can't succeed if you don't open your wallet. If you're not paying for your treatment, remember the other investments in your recovery: your relationship with your significant other, parents, friends, and children; your physical and mental health; your future. Going back to narcotics just isn't worth the price you'll pay.

That being said, narcotic rehabilitation services can be very expensive. The prices are not advertised, much as with other medical care given the somewhat secretive payment mechanism through insurance and/or governmental benefit programs such as Medicare and Medicaid. My own Suboxone outpatient treatment program was priced at about $100 per week after the first two weeks' flurry of more frequent visits totaling around $600. If this book can encourage other outpatient Suboxone treatment clinics to consider the Bock Method, maybe there will be more price transparency and a cleaner consumer model. A price point such as this is significantly less expensive than the usual street-drug daily amount spent previously; however, that often entails

criminal activity, which is strongly discouraged during detox. Overall this presents an interesting paradox.

There are hundreds of state- and federally-funded rehabilitation programs offering free (or nearly free) treatment, and many addicts have successfully gotten and stayed clean in this setting. Nonetheless, these cannot be considered ideal solutions. You may be placed on a waiting list, a delay that may eat away at your resolve to get clean. Post-detoxification care in free programs can also be sub-par, as treatment plans are not usually individualized the way they are in private treatment centers. Oftentimes, there is a standard program in place, such as the well-known Twelve-Step program from Alcoholics Anonymous, and patients are left to their own devices to fill in the gaps. When treatment comes to an end, patients are often released with little more than advice to attend counseling or meetings. This leaves success hanging on the hope that someone still suffering from addiction tendencies will do as advised, be able to self-manage the triggers, and not relapse into using drugs again.

No matter what, do not let costs discourage you from starting treatment. If you have to make a substantial financial investment to achieve a drug-free life, do not hesitate to do so. Getting treatment will allow you to be a productive member of society and saves you from incurring further drug-related debt. The benefits of a drug-free life far outweigh the expenses and efforts involved.

Understanding Your Options

The path towards recovery should begin with reducing the amount of narcotic in the body. In absolute pharmacologic terms this does not always happen, for instance, when opiate heroin is merely replaced with opioid methadone, as treatment. “Detox” does not always mean tapering. The maintenance approach replaces the illicit drug with the legal prescription replacement, whether Suboxone or methadone. Historically, “detox” meant tapering to sobriety. Sometimes this point is not well clarified in advance of starting treatment. That is one of the prime reasons underlying this book’s major mission of defining terms and treatment philosophies.

Whether it is maintenance or tapering to sobriety at the outset, the real work begins after the initial withdrawal phase: rebuilding confidence, choosing a path, recapturing respect from your friends and peers, seeking out the responsibilities and chores that may have been abandoned in

pursuit of an ultimately fruitless high. There likely will be no shortage of available therapy sessions, halfway houses, treatment groups, NA or AA meetings, clinic visits and potentially inpatient stays. The problem may be trying to figure out how many of these are useful, how much is too much, and how well their motivations match one's own.

Let's assume that it's warranted to have a few months of cooling off from an active drug-seeking phase to reclaim some of the roles and responsibilities of real life. Maintenance clinics will usually recommend at least a year, perhaps multiple years of replacement Suboxone or methadone. Groups and therapy will invariably be required for continuing the prescription. The funny thing is that the replacement narcotic (as an opioid) has nearly the same addictive properties as the previous drug, so any immediate decision to tone down treatment and do more "real life" comes with a physical cost. The easier path both physically and emotionally is to continue, but that comes at some deeper, less obvious emotional cost, being tied to a new definition of oneself as an "addict in recovery." This is definitely an improvement over being an active addict overturning all parts of life in search of drug, but it's likely not where ultimately one wants to be.

Patients who come to my withdrawal program invariably ask, "What are my chances of success? What are the odds that I will withdraw completely and be sober again?" I remind people that they are not, individually, statistics. They are people with circumstances, desires, and souls. Their chances are what they make of it. Nearly 100 percent of people who follow through, pay attention, rein in unhelpful desires and urges, listen to and follow proper guidance, and "get right" with family, faith, and friends, can expect successful long-term recovery. The percentage is obviously much lower for those who do not. The real question is how to improve *your* odds for success in any given program, on an individual basis.

This is somewhat expanded on in medical studies. In 1998, Dr. Motoi Hayashida[52] noted that treatment outcomes have more to do with "patient characteristics than with detoxification settings" and "patients with low psychiatric severity...improved on outcome measures (i.e., medical condition, alcohol use, other drug use, employment, legal status, family relations, and psychiatric status) in every treatment program, whereas patients with high psychiatric severity showed virtually no improvement in any program."

[52] "An Overview of Outpatient and Inpatient Detoxification." https://pubs.niaaa.nih.gov/publications/arh22-1/44-46.pdf.

"Wanting it," "quieting your demons," and "getting your life in order" are all crucial steps for the alcoholics studied by Dr. Hayashida, and by extension, presumably for narcotic addicts as well. All this being said, it is still useful to become familiar with the different types of programs and to determine the best initial steps.

Rapid Detoxification

Rapid detoxification implies just that: a quick flushing out of the opiates from the system. Beginning in the 1980s, and reaching some modest popularity in the late 1990s and early 2000s was "ultra-rapid detoxification," sometimes called "The Waismann Method."[53]

The patient is put under general anesthesia for a four- to eight-hour period, during which an opioid blocker (naloxone or naltrexone) is administered with medications to reduce withdrawal symptoms.[54] The theory is that it is easier to detoxify patients from opioids if they are unable to feel any discomfort during the process. This procedure decreased in popularity with a 2013 CDC report of unacceptable complications (out of 75 cases, two deaths and five hospitalizations).[55]

Trying to take the good but eliminate the bad from this ultra-rapid detox, Dr. Peter Coleman[56] developed the similar (but slower and safer) "Accelerated Detox Technique,"[57] stabilizing patients for two or three days before the opiates are flushed off the brain receptors. There is no general anesthesia or inpatient care. Essentially everybody who starts finishes within these few days and opiate-free begin on Vivitrol (naltrexone) medication, treatment. This treatment costs about $6,000, which is expensive but less expensive than a month of inpatient care. There is presumably a quicker return to work from the shorter program.

Detoxifying people is only half the battle. Keeping people from returning to narcotics is the other half. So, with these as with any sobriety approach, some follow-up treatment and preventive care are warranted. Naltrexone (Vivitrol) is given as injection or pill for some time after, likely with coincident counseling.

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[53] The Benefits of Rapid Detox | The Heights.
[54] https://pdfs.semanticscholar.org/65eb/acf7aa37e34009daa7b456bebe0059f77cca.pdf
[55] "Deaths and Severe Adverse Events Associated with Anesthesia-Assisted Rapid Opioid Detoxification — New York City, 2012.
[56] How to Choose a Medical Detox Center: An Interview with Dr. Peter Coleman
[57] Why We No Longer Do Ultra-Rapid Detoxification - Coleman Institute.

Short-Term In-Patient Detoxification

Short-term in-patient detoxification programs are intended to provide a safe, professionally supervised environment to help patients physically withdraw from narcotics over a period of three to seven days. The length of stay typically depends on the substance abused, its frequency, the amount consumed, and any concurrent medical or psychiatric issues. The goal is to cleanse the body, alleviate withdrawal symptoms, and offer a starting point for recovery. However, in practice, these programs often fall short of achieving their original purpose: setting patients on a genuine path to long-term sobriety.

While managing withdrawal pain and discomfort is one reason addicts choose in-patient detox, the programs have been co-opted for other uses. Some patients utilize short-term detox simply to lower their daily drug costs, reducing their habit from, say, $200 a day to $40. Once stabilized on a lower dose, they gradually increase usage again, only to repeat the cycle in a new detox—"lather, rinse, repeat." This endless cycle is made more feasible because many patients are not paying out-of-pocket; the costs are often covered by Medicaid, Medicare, or state disability programs. As a result, both patients and providers lack sufficient accountability, reducing the motivation to use these programs effectively.

Moreover, many short-term detox centers no longer see themselves as pathways to full sobriety. Instead, they have become stepping stones to long-term or indefinite maintenance programs, where patients are transitioned to Suboxone or methadone. Patients are often given "bridge prescriptions" to manage ongoing withdrawal symptoms and encouraged to seek aftercare rather than complete abstinence. One of my patients captured this problem clearly:

Patient Interview

> *"I went to detox. They didn't get me completely clean. They weaned me down for two days, then just sent me to another detox."*

Dr. Bock: *So you're here now, and you're not detoxed?*
Patient: *No.*

Dr. Bock: *And in other places, it's a five-day detox?*
Patient: *Yeah. They* ***call it*** *"detox".*

Dr. Bock: *Did they give you any expectation that they were going to get you completely clean?*
Patient: *No, not really. I thought they would,* ***but it was just a five-to-seven-day program. They weaned me off a little and sent me somewhere else.***

Dr. Bock: *So what's different about this place?*
Patient: *It's longer, and the expectation is that I'll actually be clean at the end of it. The other places didn't have that expectation.*

Dr. Bock: *When you left the other detox, did they give you a bridge prescription?*
Patient: *Yes. They gave me the option not to take it, but I didn't feel comfortable without it.*

Dr. Bock: *So they encouraged the bridge prescription and aftercare?*
Patient: *Yes, because they didn't believe five days was long enough.* ***And that's how long insurance will cover.***

The issue with short-term detox is that it creates the illusion of progress without fully addressing the problem. Patients often enter detox with the hope of becoming drug-free but leave with prescriptions that tether them to further treatment. For many, it becomes a revolving door of detox admissions without a real commitment—either from the program or the patient—to achieving complete abstinence. It's like attending college indefinitely without a clear goal, continually cycling through without graduating.

For short-term detox to fulfill its intended role, it must be seen as one critical step in a longer recovery process, not a standalone solution. Programs should aim to genuinely clear patients of all substances, including maintenance drugs, and prepare them for the behavioral and psychological work necessary to maintain sobriety. Behavioral changes, recognition of triggers, and long-term planning must follow for the patient to succeed. Only by re-establishing this focus can short-term detox serve its true purpose.

The key objectives of short-term detoxification, when applied correctly, remain:

- Providing a safe environment for withdrawal from drugs.
- Assisting patients in physically becoming opiate-free.
- Preparing patients for true recovery, including reintegration into society through employment, social stability, and sobriety-focused programs aligned with models used for alcohol and cocaine addiction.

Detox should not simply funnel patients into maintenance programs or perpetuate dependency under the guise of "rehabilitation." Instead, the goal should be to break the cycle of manipulation, hustling, and dependency behaviors—such as stealing, begging, and sponging—that often accompany addiction. Recovery programs should emphasize personal responsibility, abstinence, and a commitment to a drug-free life, much like successful models such as Alcoholics Anonymous. Without these realignment efforts, short-term detox will continue to fall short, offering only temporary relief while paving the way for continued dependence on "the hair of the dog."

Unfortunately, many short-term detox programs no longer believe in their own mission. They call themselves "detox," but with only five days to work with—limited by what insurance will cover—they operate more like pit stops than genuine pathways to sobriety. Patients expect to leave clean, but instead, they're handed a bridge prescription and directed to longer-term programs or maintenance plans. This endless cycle is made more feasible because many patients are not paying out-of-pocket; the costs are very often covered by Medicaid, Medicare/SSDI (disability) programs. As a result, both patients and providers lack sufficient accountability, reducing the motivation to use these programs effectively.

In some cases, addicts take advantage of the system, using short-term detox to repeatedly lower their drug doses temporarily, only to build back up and return for another round of detox. Without limitations or consequences, patients can cycle through these programs endlessly—sometimes as many as 17 admissions in 17 months (literally confessed to me by a 25 year old)—at a staggering cost to the taxpayer. Clinics, on the other hand, continue to benefit financially from this revolving door, billing at short-term reimbursement rates far higher than those associated with long-term maintenance care. It's a system where both sides, knowingly or

not, conspire against the hidden taxpayer footing the bill for an ineffective, high-frequency cycle of short-term treatments.

If detox programs are to reclaim their purpose, they must stop being placeholders and start acting as the crucial first step in a real recovery journey. They need to embody their mission, offering patients both the tools and the belief that true sobriety is achievable. It’s not enough to simply "manage symptoms" and move patients along. Programs should implement structured plans with clear expectations for recovery, while society must demand greater accountability for both patients and providers. Only then can these programs provide more than temporary relief, offering a genuine opportunity to break free from the cycle of dependency. Without this shift in focus, the revolving door will continue to spin, draining public resources while failing to deliver long-term solutions.

Medium-Term Detoxification

The "Bock Method" for Suboxone Tapering and Addiction Recovery

Overcoming opioid dependence is a deeply personal journey, and finding the right path to recovery can be challenging. From 2006 to 2014, in my outpatient medical practice, I developed a structured and practical method of tapering off Suboxone that empowered patients to break free from addiction. This method, which I call the "Bock Method" or the "Just Right" approach, draws inspiration from the “great philosopher” Goldilocks—not too long, not too short, but just right—and offers an alternative to the extremes of rapid detoxification and long-term maintenance programs, focusing instead on a balanced, medium-term solution.

Rapid detoxification programs often fail to address the underlying physical, mental, and emotional dependence on narcotics. While they may treat acute withdrawal symptoms in a matter of days, the abruptness leaves patients vulnerable to relapse, unable to build the habits and resilience needed for long-term success. On the other hand, maintenance programs, such as those relying on methadone or Suboxone for years, can trap patients in a cycle of dependency, low expectations, and negative peer environments. These programs encourage a passive approach to life, treating narcotic dependence as an unchangeable disease rather than a challenge that can be overcome.

The "Bock Method" bridges this gap. Over roughly four months, patients taper their Suboxone dose—starting at 16-20 mg per day, a lower dose than what many physicians now use (e.g., the current standard of 24 mg or even 32 mg per day). I preferred to begin patients at a dose carefully titrated to their actual withdrawal needs rather than defaulting to overly high, one-size-fits-all dosing. By addressing their symptoms precisely and tapping into their initial motivation to become drug-free, this approach made the tapering process more manageable in the long run. Patients reduce their daily dose by about 1 mg per week on average—for instance, spending a week at 7 mg per day before decreasing to 6 mg per day the following week. This gradual tapering minimizes withdrawal symptoms while providing time to focus on making real-world lifestyle changes, promoting reintegration into society rather than withdrawal from it. This medium-term process provides the support needed to sustain motivation and momentum, ultimately achieving a life free from narcotics.

What the Data Reveal

In my practice, we used the Clinical Opiate Withdrawal Scale (COWS) to track symptoms throughout the tapering process. Data from this period showed that most patients experienced little to no increase in withdrawal symptoms as they reduced their Suboxone dose. In fact, many reported feeling progressively better week by week. Significant improvements were observed by Week 10, with 99% confidence that symptoms had decreased compared to the start, and by Week 14, these gains were even more pronounced.

This approach is not for everyone, but for those committed to breaking free from the "addiction maze," it provides a viable and effective pathway. Unlike maintenance programs, this method recognizes that narcotic dependence is not akin to Type I diabetes requiring lifelong insulin. Instead, it offers a way out, empowering patients to take responsibility for their recovery and reclaim their lives.

Patient Feedback

The "Bock Method" bridges the gap between individualized care and long-term success in treating narcotic addiction. Over roughly four months, patients taper their Suboxone dose—starting at 16-20 mg per day, a more thoughtful approach compared to the current trend of starting at 24 mg or even 32 mg per day. Many physicians find it easier to simply give patients

“as much as they want,” creating a temporary sense of comfort similar to indulging in sweets at the start of a weight-loss program. However, this approach fails to address the underlying problem and may inadvertently prolong the process. In contrast, I took a different path—carefully tailoring the dose to each patient’s actual withdrawal needs. It wasn’t always easy, but by paying close attention to their progress, like a skilled coach or tailor, I helped patients reduce their doses without unnecessary suffering. This individualized approach ensured that patients were pushed just enough to make real progress, without overwhelming or discouraging them, setting them up for lasting success.

Patient surveys conducted six months after treatment highlight the success of the "Bock Method." Nearly 70% of respondents reported achieving freedom from narcotic addiction at that time, with only 35% still enrolled in treatment programs. While this snapshot reflects a promising outcome, it’s important to note that life circumstances can change over time. Even so, these results suggest that the method provides a strong foundation for patients to transition to drug-free lives, outperforming the typically low success rates seen in detox clinics.

The Clinical Opiate Withdrawal Scale (COWS) data further highlights the method’s effectiveness. This scale measures the severity of withdrawal symptoms like nausea, anxiety, sweating, and restlessness.

Here's the simplified Clinical Opiate Withdrawal Scale (COWS) table:

Symptom	Description	Scale (0-5)
Resting Pulse Rate	Measured after sitting or lying down for 1 minute	0: Normal, 5: Over 120 bpm
Sweating	Sweating not accounted for by room temperature or activity	0: None, 5: Profuse sweating
Restlessness	Observed level of movement or inability to stay still	0: Still, 5: Constant movement
Pupil Size	Size of pupils in ambient light	0: Normal, 5: Fully dilated
Bone or Joint Aches	Reported or observed pain in bones or joints	0: None, 5: Severe pain
Runny Nose or Tearing	Presence of a runny nose or tearing eyes not accounted for by allergies	0: None, 5: Constant tearing or runny nose
GI Upset	Stomach cramping, nausea, or diarrhea	0: None, 5: Severe cramping/diarrhea
Tremor	Observed hand tremors	0: None, 5: Severe tremor
Yawning	Frequency of yawning within the assessment period	0: None, 5: Constant yawning
Anxiety or Irritability	Reported or observed anxiety or irritability	0: None, 5: Severe anxiety or irritability
Gooseflesh Skin	Presence of goosebumps on the skin	0: Normal, 5: Prominent gooseflesh

Over the 15-week tapering process, patients **not only** reduced their Suboxone doses but consistently reported **essentially the opposite of withdrawal: feeling better week by week**! For instance, by week 10, patients showed a significant improvement, with a high likelihood that their withdrawal symptoms had eased compared to the first week (after they had stabilized from the initial transition from there previous "drug of choice" opioid/narcotic, and remained on maximal replacement Suboxone dose, ~16 mg/day).

Our program guided patients through a steady taper, reducing their Suboxone dose by approximately 1 mg per day each week. By week 14, even as their doses had dropped to just 1 or 2 mg per day, patients not only reported fewer withdrawal symptoms but actually felt better than they had at 16 mg. Our in-house study confirmed this with nearly 99% statistical confidence using T-square analysis. However, the benefits went beyond physical relief—patients also

experienced a sense of accomplishment and renewed purpose. They weren't just getting off Suboxone; they were rebuilding their lives, reconnecting with society, and proving to themselves that they could thrive without relying on drugs.

A key part of this transformation was the shift in mindset. Instead of chasing instant gratification through addiction-driven hustling, patients began to value real-world achievement. The impact of this was best captured in a conversation with one of my patients:

> *I would say a big reward in itself is that I'm actually earning this – rather than just out there hustling or doing what I had to do to get money and just instant gratification. I worked today, and it was just an orientation day—I'm not even getting paid for today—but when I left, I felt really good, and that's a reward in itself. It really is. So earning it does mean so much more. Makes me want more.*

So, does any other drug clinic mention this kind of thing? Have you been to others before?

> *I've been to others.*

And did any of the other treatment places talk about the centrality of making your way through the world yourself?

> *They didn't. And oh, definitely—just hearing the tape on my first day here, during intake, that was motivation in itself. Everything you said in that tape just hit a spot that other places didn't even talk about.*

Specifically, what stood out to you?

> *What I got mostly from the videos was not to feel sorry for myself. After I watched it, I realized I always did the whole "poor me" thing, playing the victim. And the video just laid it out—don't feel sorry for yourself, because I'm the only one who's going to get me out of this. That's what I liked about it. It was like constructive criticism. Even being with you—a lot of our talks hit the spot. But in those other programs, they didn't care about anything like that. It was either,* "You did it," "You didn't," "Whatever."--- ***But even though it is on me to make this change, I got that little push, just in the little time I've been here. I really have. And even my loved ones***

have seen the change—without me even saying it. That makes me feel good. It does. It makes me feel like people care.

This structured approach, combining gradual dose reduction with personalized care, minimizes withdrawal distress while supporting patients in making real-world changes. With its focus on both clinical outcomes and personal empowerment, the "Bock Method" provides a clear pathway to freedom from narcotics and a healthier, more independent life.

Building a Movement for Change

Although my practice is no longer active, the principles and data gathered during those years remain relevant. The "Bock Method" demonstrates that recovery is possible without lifelong dependency on maintenance programs. However, broader adoption of this approach requires a shift in consumer demand. Just as people have pushed for organic food options, informed individuals must advocate for better detoxification choices, challenging providers to meet their needs.

Withdraw to Freedom aims to empower patients and their families with the knowledge to demand more from addiction treatment programs. By rejecting the extremes of "too short" and "too long" approaches, this medium-term solution offers a roadmap to recovery—one that respects the patient's highest motivations and reinforces personal responsibility.

For those ready to break free from the chains of addiction, the "Bock Method" provides a hopeful, practical, and achievable path forward. It does not promise an easy journey, but it offers the clarity and tools needed to succeed. With this method, patients can move beyond survival and into lives of purpose and fulfillment.

Long-Term Detoxification and Residential Treatment

Long-term residential programs provide 24-hour care in a non-hospital environment. The duration of these programs is anywhere between three months to one year. Those who enter these programs are medically detoxified from narcotics either beforehand or during the first few weeks.

As a form of therapy, it calls for considerable investment in terms of time, money, and effort. You can expect to be removed from your regular social environment and put in an altogether

different set up where you'll interact only with other patients and staff members of the center. You will live in a regulated environment, with a fixed schedule, from the time you wake up until you go to bed. Long-term in-patient treatment is recommended for addicts who have more severe cases of addiction. Those who have been on drugs for years or have a repeated tendency to relapse are considered prime candidates for this therapy.

The benefit of these types of programs—if they are good ones—is that they require you to reflect on the underlying psychological reasons for your addiction, the society you live in, and your place in it. Effective long-term residential programs recognize the very real fact that many addicts have additional issues (legal, criminal, psychological) to deal with in addition to their addiction. Some centers offering long-term therapy have employment and/or psychological training programs ensuring you do not re-enter society without adequate preparation. This form of therapy is highly individualized, and the treatment takes place in a structured manner.

While these programs have high success rates, most people simply don't have the option of putting life on hold for such an extended period. Furthermore, ongoing after-care is just as important in this therapy as in any other.

Replacement Drug Therapy Options

It's important to understand some basics concerning how, and why, replacement drug therapy works.

As a narcotic addict, you are addicted to some form of opiate that creates artificial endorphins in the brain. Endorphins are responsible for happy, warm feelings, like those experienced when falling in love or receiving good news. Over time, these drugs prevent your brain from producing naturally occurring endorphins, forcing you to use the chemical ones in order to feel happiness. After detoxification, returning the brain to its normal function takes time, which is precisely the reason relapse rates are astronomical without ongoing treatment.

By taking the appropriate dosage of a replacement drug, and following a well-timed tapering plan, you can continue experiencing positive feelings while your body and brain work to restore normalcy.

There are two primary types of replacement drugs: agonists and antagonists.

Full agonists (like methadone) work by activating the opioid receptors in the brain, producing nearly the same effect you feel when high. Partial agonists (like buprenorphine, a main

component of Suboxone) also activate the opioid receptors, but to a lesser extent than a full agonist, producing a muted effect.

Antagonists, on the other hand, block opioids completely, attaching to the opioid receptors without activating them.

Methadone Maintenance Treatment (MMT)

Until the introduction of Suboxone in 2002, methadone, a narcotic, was widely used to treat opiate addictions. Methadone, a synthetic agent introduced in the 1960s, works by blocking the brain receptor sites that are affected by opiates, resulting in relief from a craving for heroin or other opiates and further reducing the chances of relapse. As this drug is given in regulated doses, it reduces withdrawal symptoms without making patients feel high, allowing them to be productive members of society. A patient receiving MMT is required to visit the physician or dispensing center every day for his daily dose.

Unfortunately, methadone has become a problem of its own. When used carelessly, it can have serious side effects. An overdose can slow down breathing; at times breathing becomes too slow and may even cease. The drug has many other drawbacks, perhaps most significantly that it triggers the brain's pleasure centers, making it possible, even likely, for an addict to develop a whole new addiction. Appendix 1: The Myth of Methadone is devoted to further discussion of MMT.

Suboxone

Suboxone is a focal point within the Bock Method—Withdraw to Freedom, as it is (in my experience) the best replacement-drug therapy available. It is discussed only briefly in this chapter, as the book deals with it extensively in later sections.

Heroin was invented to treat morphine addiction; methadone was invented to treat heroin addiction. Likewise, Suboxone was developed to treat narcotic addiction. Its real success, however, depends on the understanding that it is an opiate used to block other opiates in order to alleviate withdrawal symptoms and to allow reasonable time for gradual and virtually symptom-free withdrawal. Suboxone therapy is currently the best replacement-drug option on the market, and it can help many narcotic addicts transition to a drug-free life, as long as the tapering process is carefully timed.

Suboxone is a combination of buprenorphine, an opiate agonist, and Naloxone, an opiate antagonist. Patients prescribed Suboxone are not required to visit their physician for a daily dose, the drug does not (as much) trigger the brain's pleasure centers, and the drug is much easier to taper off, making the potential of misusing Suboxone much less than methadone. The initial doses are always administered under a physician's supervision to determine the maintenance level of the dose. The drug is then slowly tapered off, with every tapering period lasting two to four weeks. This detoxification period allows appropriate time for patients to get over their "love affair" with narcotics, reframe their thinking, and acclimate to a drug-free life.

Deciding on the Right Treatment for You

While deciding on a line of treatment, keep the following points at the back of your mind:

• What worked for a friend may not work for you.

• Immediate and easy availability of treatment is a crucial factor for positive outcomes.

• Effective treatment will attend to your multiple needs, not just the immediate need to detoxify. Medical, social, psychological and even financial and legal problems will be addressed by an effective treatment program.

• Medication and counseling will form an integral part of the treatment.

• Remaining in treatment for an adequate period is an essential for quitting the addiction successfully.

• Continuous and frequent assessment of your treatment plan is essential.

There is no right or wrong way to achieve recovery. The process is highly individualized and should be treated as such. Without exception, addiction is a complex medical and social issue. Abuse of drugs alters the structure of the brain, having an impact even long after the use of drugs has ceased. Relapse and addiction to alternative drugs post-treatment are issues that have had a detrimental impact on the efficacy of various therapies. No single therapy can be an answer for all patients and addictions. To be effective, the therapy opted for has to assess the medical, psychological, and social position of the patient. As you continue reading, we will dive further into each of these issues.

The mind plays a very important role in detoxification. You will need to call upon the depths of your courage, willpower, and optimism to see yourself through not only the beginning stages

of detoxification but the ongoing temptations in the weeks, months, and even years that follow. You've committed to the goal of becoming drug-free; now paint a detailed mental picture of exactly what that looks like. Envision a healthier, happier version of yourself in control of the choices you make and the subsequent results. Imagine satisfying relationships with friends and family members that aren't defined by needing, wanting, or getting drugs. Picture yourself in a career you enjoy, where you are respected by your peers and enjoy going to work every day.

No matter how grim your situation may seem right now, these scenarios can become your reality if you want it badly enough *and* seek out the right treatment and support. Do not allow prior failures to discourage you. All roads to recovery have bumps and pitfalls.

7. Finding the Right Doctor

The Bock Method is a unique, regimented, four-month program, which when combined with behavioral changes, facilitates complete freedom from narcotic use and abuse. It includes three distinct parts:

1. Personal accountability. The right doctor will hold you to a high standard of personal accountability. This is the best and most reliable way to facilitate detoxification and help you achieve a narcotic-free life. This means your doctor will provide you with a treatment support system that includes counseling and behavior monitoring.

2. Suboxone as a replacement therapy. As discussed at length in Chapter 9, Suboxone is the superior replacement drug therapy option. Its potential for abuse and addiction is less than that of methadone, and it does not interrupt daily life activities to the same extent as other options.

3. Four-month tapering period. When deciding on a doctor, you must establish your desire to achieve complete sobriety within a definitive time frame of four months. Without this boundary, Suboxone treatments could continue indefinitely, leading to a new dependency on the treatment drug. The right doctor will acknowledge this fact and be willing to employ a Suboxone-tapering treatment protocol that aims for full, genuine sobriety.

In the pages that follow, you will come to understand the importance of finding the right Suboxone doctor. There are over 50,000 clinics and doctor's offices in the United States[58] that are authorized to write Suboxone prescriptions for opiate addicted patients. But not all of these locations and physicians will have access to the support systems and accountability measures you need to achieve sobriety. It is your responsibility to ensure your doctor follows the Bock Method for Suboxone tapering. It is also key to confirm your doctor will whole-heartedly embrace and affect a personalized accountability plan. Leading a productive, sober, and rewarding life after detoxification is your goal, so learning the tools to maintain long-term progress is a necessary part of treatment.

When considering doctors, ask them to explain their established approach, including the duration of the complete program, length and pacing of tapering, and the general school of

[58] https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator

thought concerning drug replacement therapy. Working with a doctor who understands opiate abuse as an addiction rather than a disease will empower you to achieve full sobriety. As with any addiction such as smoking, alcohol abuse, or gambling, people can, and do, stop with appropriate support and treatment.

Make Sure Your Doctor Works for You

Never forget that as the patient, you are a *consumer*. While you are trusting your doctor to help you and make decisions based on his or her knowledge and experience, do not allow yourself to be guided in a direction you don't understand or that feels haphazardly suggested. You should always feel comfortable asking questions and sharing goals, and feel your doctor is moving your treatment in a direction that will best meet your needs.

It's all too common for patients to view doctors as "all-knowing" and "always right." This is, essentially, applying the "parental" model of thinking to healthcare, wherein a child looks at his parent(s) as the pinnacle of knowledge and takes every answer as absolute truth. Of course, we outgrow this mindset rather quickly at home, but it persists in medical settings for years--in some cases, for one's entire lifespan.

While it is true that earning the title of "doctor" requires years of intense study and hands-on practice as well as the successful completion of rigorous national and state exams, this does not, or at least should not, render you powerless in terms of making decisions about your health. Perhaps more aptly, working with a doctor does not relieve you of responsibility; your care is not out of your hands. Success and sobriety are ultimately achieved by gaining understanding about yourself and the process. The easiest way to adopt this mindset is by not eagerly accepting everything your doctor suggests as infallible. Internet search engines make it simple to do your own research about any suggested treatment protocol. You can read first-hand experiences from people in recovery, people who've relapsed, and people who've tried multiple avenues of treatment. There are credible research articles that are also readable! In short, never forget that this is your journey and the choices you make are yours to own; after all, if you fail, your doctor will certainly not take responsibility.

Your treatment must be highly personalized to account for any individual variables that may affect your progress. Part of this responsibility lies in your hands. When you arrive at your

doctor's office, be prepared to provide a detailed history of your addiction struggles and your sobriety goals. Your living conditions, support system (or lack thereof), employment status, and financial obligations should all be part of the conversation.

Go to your first appointment with a list of questions geared toward finding out how your doctor can help you. Here are some example questions you might use as is, or adapt. They will help establish your goals and guide the development and direction of your treatment.

- What kind of support/help will you and your staff provide to help keep me on track with my journey to sobriety without developing an indefinite dependency on Suboxone treatments?
- How will you and your staff help me break and remain free of the cycle of narcotic addiction while ensuring I do not develop a Suboxone dependency?
- My reasons for wanting to become sober are_____. How will your approach to Suboxone treatment complement this?
- What help will you and your staff provide, or give me access to, resources that will help me maintain continued sobriety in the face of life's stresses?

With the answers to these questions, and an honest accounting of your history and current circumstances, you and your doctor can agree on a treatment plan. You can also ensure the doctor's complete and informed participation in what must be a detailed treatment and accountability process to help you move into a narcotic-free life.

8. Personal Accountability - Make a Plan!

"Would you tell me which way I ought to go from here?" asked Alice.
"That depends a good deal on where you want to get," said the Cat.
"I really don't care where," replied Alice.
"Then it doesn't much matter which way you go," said the Cat.
- Lewis Carroll, Alice's Adventures in Wonderland (1865)

The Cheshire Cat's advice to Alice is a reminder that you will only reach your goal of a drug-free life if you set your sights firmly on getting there. Your odds for success are much greater if you can envision what your life will look like after treatment and lay out a well-formulated plan of attack. Every journey that we take in life is intended to teach us something, but what we actually learn is up to us. Choosing to begin your journey toward sobriety with your eyes wide open and committed to taking small, but meaningful, steps in the right direction is the best path forward.

In this chapter, I will discuss how sobriety can be achieved by splitting your goals into short-term, medium-term, and long-term. However strong your initial impulse to get clean may be, sobriety isn't likely to be achieved in the absence of a well-thought-out plan.

Plan to Succeed

Planning simply refers to deciding in advance what is to be done and how. It specifies a future course of action in concrete terms. The target to be achieved is broken down into numerous small steps which are to be tackled in order. Without proper planning, reaching your goal is no more possible than it is for a rudderless ship to reach its destination. In the words of Lester Robert Bittel, "Good plans shape good decisions. That's why good planning helps to make elusive dreams come true."

The value of planning cannot be over emphasized. Through planning, even the most distant goals become reachable. And when it comes to something as strenuous as narcotic withdrawal, one simply can't do without proper planning.

Planning for Detoxification

Withdrawing to freedom cannot be achieved in a day or two. Your goal must be broken down into smaller goals. In doing so, you allow yourself small victories that serve as motivation to persevere and boost your morale.

Short-Term Planning

Short-term planning should cater to the most urgent and immediate goals. It provides the strong foundation necessary to reach your big picture goal of complete sobriety.

The short-term goals encompass:

• Stopping the usage of self-administered illegal or prescribed narcotics.

• Putting a full stop on illegal activities such as theft, robbery, writing bad checks, stealing, and manipulating credit cards and bank accounts.

• Recognizing and admitting the magnitude of the problem(s) brought on by narcotics and taking corrective action.

• Stripping off negative friendships that lead to addiction. All ties with dealers and peer users must be cut completely.

• Forming and maintaining positive friendships conducive to the goal of detoxification.

The short-term goals listed above can largely be achieved during the initial detoxification phase. Adherence and submission to your program is an absolute necessity. Once the short-term plans are met with success, your confidence will grow by leaps and bounds and you'll be ready to move ahead with medium term plans.

In these early stages, you may find yourself in dire need of constant support, encouragement, and counseling. That's okay! You'll be under immense pressure. Under such circumstances, it is normal to seek out sources of support and motivation. Your doctors, nurses, and family members should appreciate your efforts and provide their unwavering support. Always bear in mind that it is not easy to move oneself away from drug dependency.

Medium-Term Planning

As you move from active addiction into the initial phases being drug-free, plans for sustained abstinence and success should be formulated and implemented. Medium-term planning focuses attention on the following goals:

- Building a foundation of strategies to avoid drugs and illegal activities.
- Modeling a better life through engagement in healthy leisure activities.
- Recognizing and disqualifying excuses that get in the way of your success.
- Promoting more deeply satisfying personal and social relationships.
- Rewarding acceptable changes.

At its root, planning helps you keep score in terms of your progress. Give yourself credit each time you overcome a craving, say "no" to a temptation, and engage in positive behavior.

This is the counsel I provide my patients: To get off drugs for good, you need to make changes to your lifestyle. You must begin making more positive decisions in all areas of your life. When you encounter an obstacle, such as a job loss or a divorce, you may be tempted to turn to drugs to make the problem go away, but the truth is you're just pushing your issues off until later. They will ultimately need to be dealt with. Decide *today, right now,* that you are going to do things differently. Plan for doing things differently!

Connect with Nature

Being outside and enjoying sunshine, green grass, tall trees, and all the wonders of Mother Nature is one of the best ways to soothe a tired soul and learn how to appreciate a sober world. Hiking excursions, picnics, walks along the beach with family or friends can be rejuvenating.

Prioritize Yourself

It's time to realign your priorities and put your health first. You've already gone through the initial stages of detoxification, so you're already well on your way. Now, focus on getting adequate sleep, drinking enough water, and eating a balanced diet. As soon as you can, start to implement exercise into your daily routine. This can be anything from walking or bike riding to going for a swim or wall climbing at your local gym.

Find Your Lost Faith

If you are (or were) a religious person, reconnect with your church or join a new one. The power of faith and prayer cannot be underestimated as a tool to help you succeed.

Give Back to Society

While you were using, you were *taking* from society. You can reverse that by getting involved in community service activities like visiting nursing homes, volunteering with Habitat for Humanity, or packing lunches for low-income children. These types of activities present opportunities to meet people who are less fortunate and to realize that narcotics is not the only way to cope with pain. Being involved in your community takes the focus away from your addiction and shifts it to the outside world.

Many of my patients have successfully gotten clean while in prison, where a sobriety plan is developed and enforced by those in positions of authority. They simply don't have access to drugs, and they also have plenty of distractions. Jail time comes along with a regular schedule, time to work out, and sober socializing. Of course, I don't want anyone to return to prison, but I do think it's helpful to remember what the human body is capable of and what it felt like to be healthy.

Long-Term Planning

Successful short-term and medium-term planning ultimately give way to long-term planning. By now, you should be reasonably sure of your progress and confident that you can win the battle against addiction. Nevertheless, remain cautious, as a single mistake can set you back several steps. Your long-term plans should be developed very thoughtfully so that nothing important is left out.

Long-term plans are aimed at ensuring a life-long, drug-free existence and establishing lasting relationships with the outer world. You will soon need to face the challenges of daily life as a responsible adult, effectively making smart choices that keep you drug-free.

Long-term planning should cover the following:

• Planning "re-entry" in the drug-free world. For this purpose, one can investigate outpatient programs, support groups, therapists, psychiatrists, or family counselors.

• Focusing attention on long-term, realistic employment goals. This may involve training and education.

• Coming out of the dream world and accepting the realities of life.

• Seeking out ongoing support. Using the same diligence exercised in choosing a doctor, you can begin to build solid relationships with people who are invested in your continued sobriety.

Freedom is a wonderful thing, but for some people, too much freedom can be dangerous. In the old days, men would join the navy after a bad break-up. It helped to keep them busy with specific duties and schedules, provided the camaraderie of other seamen and officers, and gave them purpose in order to overcome the pain of the break-up.

Today, most people get that regimentation, camaraderie, and sense of purpose from work. Having a job while undergoing detoxification is a huge benefit. Instead of focusing on the drugs, you can concentrate on working hard, earning some money, and rebuilding your life.

If you don't have a job, dedicate your time to finding employment. Seek help to create or update your resume. Familiarize yourself with the job market by registering on job boards. Look in the mirror, and if you don't see a reliable, hardworking employee staring back at you, there's work to do. As a former drug addict, your appearance may not convey the message that you're ready to start a new job. Get yourself in shape, find proper clothing for interviews, and read up on self-presentation skills. You need to look like someone who has it together, someone ready to walk in and start the job tomorrow. One great way to stay busy and better prepare yourself for employment is volunteering. You'll boost your resume, make new connections, and give your new life some meaning.

Another reason to keep busy with healthy activities like volunteering and seeking employment is to avoid using other substances as a crutch, even ones that may seem less harmful, such as marijuana and alcohol. These substances can lower your inhibitions and affect your reasoning. They can make it easier for you to succumb to your desire for narcotics. You want to regain control of your body and your life. In order to do that, you need all of your strength, so you must avoid all substances, no matter how harmless they may seem.

I tell my patients that they have to do the hard work. We fix no one at my clinic. We just give them a ladder. They are the ones that have to climb out. If they climb three-quarters of the way out, then stumble and fall, they've done all that work for nothing. Complete the process: climb all the way to the top and stay there. Once you do this, you'll find you feel better, look better, and

are better prepared to cope with whatever life throws at you. Remember, at the end of it all is a new life–your own.

A Note About Joining NA or AA

Personally, I don't encourage my patients to attend Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meetings. These groups usually tell people that they are powerless, but that's not true. I've noticed that when people talk about relapses, it's in the context of *something that's happened to them*. There's no acknowledgment that the decision to use again lies solely in the mind of the addict.

You need to empower yourself to make a change, not admit that you have no power. In NA and AA meetings, people tend to focus on all the negative events in their life. What they should be doing is moving beyond the negative and focusing on making positive decisions for the future. You have the power to take drugs out of your life forever, and you should seek out more productive uses of your time than attending NA or AA to help build your self-esteem, aid your community, and make you happier in the long run.

The Paradigm Shift

Achieving success here is no easy feat. As you've learned, it will require plans, commitment, and iron-willed determination. You must be prepared for a complete mental, physical, emotional, and social transformation.

Successful detoxification and sobriety is based on a paradigm shift in outlook and behavior. Treatment alone won't change your mindset; neither will any lone physician or family member. Your doctor won't, for instance, ditch the bad boyfriend. Your father, similarly, isn't going to apply for a job on your behalf. Success is up to you.

Committing to a four-month detoxification and sobriety program, however, will provide some basic parameters that will allow you to succeed. Making detailed short-, medium-, and long-term plans will build a solid foundation as your efforts become habits.

What if You Fail?

Even perfect planning, unfortunately, does not guarantee perfect results. It only increases the probability of success. Even the best laid plans can fail, but this merely means reevaluation is in order, followed by the establishment of new, better plans.

Always remember sobriety is not a one-day task but a lifelong commitment. You have to strive for it every day. Failure should never be considered a dead end. In the case of momentary defeat, review your existing plans, analyze any faults, formulate new plans, and adhere to them wholeheartedly until your mission is achieved.

To conclude, I would like to quote some very inspiring words from Henry Ford: “Failure is the opportunity to begin again more intelligently.”

So, make a pledge to move toward sobriety and away from drugs each day and prove yourself worthy of this beautiful gift called “Life.”

9. All About Suboxone

Suboxone is the trademarked name for the buprenorphine/naloxone compound produced by Reckitt Benckiser. It was approved by the FDA in 2002 and has become, for many physicians, the preferred drug for detoxification and maintenance therapy, and with good reason. Unlike other replacement drug therapies like methadone, Suboxone's unique combination of ingredients allows addicted people to move forward in their recovery journey without complicating matters by introducing a new drug with a high risk for abuse.

In the United States, the government has classified Suboxone as a Schedule V narcotic, one deemed to hold a relatively lower risk for addiction than other narcotics, although notably the scheduling of such controlled substances is not an exact science. For instance, as of 2024, under federal law marijuana is still a Schedule I (most severe) narcotic, while in twenty-four states and terrritories, it's legal for private purchase and consumption. Go figure that out!

Buprenorphine

In order to best understand how Suboxone works, we'll first examine its components. Its active ingredient, buprenorphine, is a partial agonist synthetic opioid discovered in 1966. It was initially viewed as a painkiller, but over the next thirty years its use in treating narcotic addiction was fully realized. At that point, buprenorphine was introduced as Subutex, a sublingual tablet. Unfortunately, it did not take long for drug abusers to realize its potential to produce a high, albeit not one as intense or disorienting as, say, heroin. Not surprisingly, buprenorphine abuse at the street level became problematic with up to 28 percent of patients who were prescribed the drug admitting to selling it, sharing it, or giving it away[59].

This ultimately led to the development of Suboxone, which combined naloxone with buprenorphine to significantly reduce its euphoric effects. Currently, Subutex is no longer on the market and use of buprenorphine alone is restricted to pregnancy and early-phase methadone switchover.

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[59] Lofwall, Michelle R. MD; Martin, Judith MD; Tierney, Matt NP, CNS; Fatséas, Mélina MD, MPH; Auriacombe, Marc MD, MSc; Lintzeris, Nicholas PhD, FAChAM Journal of Addiction Medicine, Sept Oct 2014 Volume 8, Issue 5, p. 327 - 332

Naloxone

The predominant Suboxone formulation was created at the urging of the National Institute on Drug Abuse, adding naloxone to prevent misuse by injection or snorting, thereby diminishing street sales. Naloxone is an opioid antagonist. It binds to opioid receptors and blocks the effects of other opioids, preventing any high from occurring. Essentially, this combination of buprenorphine and naloxone checks all the boxes: given at the correct initial dosage, the buprenorphine component allows patients to gradually withdraw from opiates while working on their recovery while the naloxone serves to reduce the high that so often leads to addiction and abuse.

So, How Exactly Does Suboxone Work?

Let's start by making the distinction between *opiates* and *opioids*.

Opiates are found in and derived from opium, while opioids also include synthetic substances that imitate opium. The two produce similar effects, since both connect to the same receptors in the brain. So, for our purposes this is something of a "distinction without a difference;" as far as your brain and body are concerned, these two are essentially indistinguishable terms.

Suboxone is considered a partial opioid agonist, which means it attaches to the same receptors in the brain as other opioids, but produces lesser effects. Because it includes naloxone, when Suboxone attaches to the brain's pleasure receptors, it blocks other narcotics' ability to do the same. This does not, however, mean it is merely a "blocker"; it is a slightly less aggressive replacement. If abused, Suboxone is a fully addictive opioid in and of itself, although slightly less potent than the addictive narcotics it is intended to replace.

This is the process of opioid addiction and how Suboxone works:

People feel pleasure and experience good feelings as they accomplish a task, earn commendation, fall in love, exercise, witness happiness amongst others, or perform a favor. The sense of pleasure appears as a *consequence* of these productive activities, when opiate-like substances called *endorphins* are produced by one's own brain, as a reward, because they trigger a feeling of pleasure.

Narcotics, in the form of opiates and opioids, chemically and physiologically mimic the

body's natural endorphins, producing a pleasurable high. But it is essentially stolen, not validly achieved, coming not as a consequence of a productive action, but simply from ingesting a drug. As the opioids leave the receptors to which they connect in the brain, these good feelings fade. Since the productive behaviors and sensibilities that would ordinarily maintain this pleasurable reward system's natural high are not present, withdrawal symptoms and cravings ensue, creating the perceived need to use more of the drug.

Opioids continue leaving the receptors until a person begins to experience a moderate state of withdrawal, which is when Suboxone treatment should begin. It is important that this moment is identified and determined by a skilled professional.

Suboxone attaches to the receptors and, with the right dosage, it fills most receptors, blocking other opioids from attaching.

You may be thinking, "Well, then what's the difference between Suboxone and heroin?"

Although Suboxone is also an opioid, and thus is also addictive and can produce opioid effects such as euphoria and respiratory depression, its maximal effects are much less pronounced than those of opioids like heroin and methadone. At low doses, it produces sufficient effects that last up to seventy-two hours, which means people addicted to opioids can stop their misuse of opioids for a relatively significant time without experiencing symptoms of withdrawal. Of course, the effects increase with increased dosages, but only up to a certain point where the effects stabilize and produce the ceiling effect; that is, increasing the dosage won't increase the effects. Because of this, compared to stronger opioids, Suboxone has a lower risk of addiction or abuse.

Throughout the years, Suboxone has become increasingly popular, and its worldwide use in treatment has surpassed the number of addicts being treated with methadone. This boom happened, in part, due to the fact that in the year 2000 it was made legal for authorized US doctors to treat (or replace) addiction to opioids such as heroin and OxyContin with buprenorphine (also an opioid). Suboxone is the first non-methadone opioid narcotic to have received this type of approval, paving its way for use in office-based treatment of opiate addiction.

The Benefits of Suboxone

We have looked at Suboxone's history, the way it works, and how it can go wrong. But what are the main benefits of Suboxone? Suboxone has become a popular treatment for these reasons:

• It can decrease cravings and relieve withdrawal symptoms. This helps addicts remain in treatment and gain control over their addictions.

• People can take it once a day, an improvement over the frequency of drugs like methadone.

• It doesn't have a high street value, because it's not injectable for a more immediate high. This somewhat lowers the incidence of patients selling their prescriptions on the black market and encourages them to stay on track.

Clinical trials have also established that Suboxone:

• Suppresses symptoms of opioid withdrawal.

• Reduces cravings for opioids.

• Reduces illicit opioid use.

• Blocks the effects of other opioids.

Choosing Suboxone as a replacement drug will likely allow you to treat your opioid dependence with privacy, confidentiality, and safety. Most people who chose this route of recovery don't need to be hospitalized, leave their homes for extended times, or visit a clinic every day. This allows more time for family, friends, work, and healthy leisure.

Avoiding "Fool's Gold"

Most people have heard of "fool's gold," the common name for the mineral pyrite. It's shiny and impressive, just like actual gold! What does this have to do with Suboxone? Well, let's say that Suboxone is our "gold." Just like the Gold Rush of the 1800s, everyone is excited about this new discovery, and everyone wants to get their hands on it. In fact, Suboxone has become the standard in addiction treatment—that is, it's considered a model for (and better than) other replacement-drug therapies. Becoming the standard, though, poses a few problems, especially when the treatment itself becomes standardized. In order to be effective, Suboxone use must be tailored to patients' needs, not applied the same way to every case.

The notion that recovery can look the same for everyone is closely connected to the misconception that addiction is a disease. Just as diabetes is treated with a standardized

medication and treatment approach, Suboxone is being prescribed on a long-term basis for the bulk of patients. Viewing Suboxone in this manner *changes it into fool's gold*: still superficially attractive, but much less valuable than the "real deal," which in this case correlates with a closely supervised four-month tapering process.

Many addicts are under the false impression that Suboxone is just a blocker. It is, as discussed, a narcotic. This misunderstanding is partially the result of poor marketing attempts that oversimplify Suboxone rather than fully explaining its two active ingredients, buprenorphine and naloxone, as discussed above.

In sum, all opioids can cause physical dependence, even a partial opioid agonist like Suboxone. While the effects of Suboxone are mild compared to that of full agonists like heroin, the side effects can be similar and an erroneous administration can produce dependency.

So, how can we avoid Suboxone's becoming "fool's gold"? By limiting it. For example, in many treatment programs, if you fail a drug test, your dose of medication will be increased. The line of thinking here is that you must be feeling so terrible on whatever replacement drug is being used that you needed to do heroin (or Oxycontin or fentanyl, etc.). Essentially, the replacement drug *wasn't enough*, so you're given more. This process is commending you for relapsing and affirming your desire to get high by getting you even higher. If a child breaks into a cookie jar, you don't reward him with more cookies, do you? Of course not. That would teach the child to continue breaking into the jar.

Here's another way to look at it. Let's say you had a problem drinking too much whiskey, and waking up every morning dizzy and with a headache. What if I told you to drink vodka to get rid of your symptoms? Would you be cured? Well, you might stop drinking whiskey, but you'll likely start drinking more and more vodka. Replacing one addiction with another will never lead to sobriety.

With this comparison in mind, it's no mystery why people relapse and end up taking more drugs to get off of drugs when just the opposite should be occurring.

Suboxone: A Unique Tool, Not a Substitute Opioid

Building on the discussion in the previous discussion, here we'll talk about the "modality" of Suboxone. The term "modality" refers to the way a thing is used, and most things have more

than one modality. Think, for example, of a hammer. If you watch *The Sopranos*, you know you can break fingers with a hammer, or you can build a house.

As you've learned, in the case of Suboxone, the mode of use is frequently incorrect.

The problem is that Suboxone is being used like methadone. Methadone clinics keep patients for five or more years, which isn't an attractive option for anyone. It's commonly referred to as "liquid handcuffs": Once you start, you never stop. When an addicted person hears that Suboxone requires fewer visits to the doctor or clinic and can reduce recovery time, they don't realize that this result is only possible with a proper tapering regimen. Many doctors, however, use Suboxone the same way as they do methadone, prescribing the maximum dosage for the maximum amount of time and without a tapering protocol. This method does very little by way of helping you reach sobriety.

10. Moving from Maintenance to Sobriety

To withdraw to freedom, first you must acknowledge that "drug-free" does not include being in a rehabilitation center or in a treatment program. Just because you are not scheming to procure drugs illegally does not earn you the drug-free award. To truly say you are drug-free, you must lead a life without the intake of any type of non-medical drug. This life entails total freedom from the drug regime, with complete independence, instead of transitioning from one drug to another.

While some authorities on addiction treatment methods consider ongoing methadone or Suboxone narcotic-substitution therapy as constituting a drug-free existence, I reject this proposition completely, and so should you. Switching from one drug to another, even under legal and controlled circumstances, is like climbing out of a well only to fall into a pit, essentially a meaningless endeavor serving no purpose at all. As such, you must avoid being placed on an indefinite dosage of Suboxone (or any other substitute drug) so the road to a drug-free life is clear and true.

This is not to say that the controlled and tapered use of Suboxone is not a completely viable step on the road to recovery, just that it cannot be considered a long-term solution. When narcotics leave the body abruptly during detoxification, users experience painful withdrawal symptoms. To help patients avoid the compulsive desire to use opiates to cope with that pain, a controlled quantity of a replacement therapy drug is justified.

People often arrive at my office asking to start "Suboxone treatment." I always tell them, "Suboxone isn't a treatment." It's another narcotic, chemically and physiologically not tremendously different from the ones people are trying to remove from their lives: heroin, Oxycontin, fentanyl, methadone, Percocet, etc. The brain can't fully get clean if the body is still absorbing a narcotic, even if it is a legal one being used as "treatment."

Suboxone may not get users as high as other street drugs do, but it's still powerful stuff. Case in point, if you gave Suboxone to someone who has never taken drugs before, he'd be passed out for the next ten to twelve hours, at least. And of course it can be just as addictive as other narcotics. People line up in front of Suboxone clinics just as they do with methadone clinics. It's perfectly legal and paid for by the state, but that doesn't change that these people are addicted to

drugs. In fact, Suboxone has now made its way onto the street, being sold for recreational use (typically by patients who want to use the money to purchase their old drugs of choice, heroin, fentanyl, or methadone, for instance).

So why do I choose to prescribe Suboxone at all? Well, at my clinic, the goal is to stop the cycle and really get people clean. In order to do that, they need to stop their ongoing narcotic, and (as we all know), "breaking up is hard to do." As you read earlier, the process can be aptly compared to falling out of love. After a relationship ends, one party is left miserable and convinced they will never again be happy. Quitting narcotics produces a similar emotion. It's those moments, right after the break up, that are the hardest. The pain is raw. The memories are fresh. This is when it's tempting to pick up the phone and try to reignite the relationship. Often, people do this even when it isn't the right decision.

But, if one's impulses can be checked, things get better more quickly than anticipated. With each day, and then week, that passes, you're thinking about the other person less and less. Of course, the more productive and busy you are, the easier it is to move forward. Before you know it, the pain is gone. You've moved on. All you needed was time and separation.

As a drug addict, you are in a love affair with your drug of choice. Suboxone will buy you time and some separation, helping you move on and making it easier not to fall backwards. The key is to avoid starting a new love affair with Suboxone. Many treatment programs start patients off with a high dose, as many as three 8-mg tablets a day, and don't have an exit plan.

Harmful Effects of Unlimited Suboxone Maintenance

Suboxone, like other opiates, is a powerful drug which can lead to dependence. Suboxone, while not having quite the full opiate-agonist effect of methadone, is still a highly addictive substance. Long-term maintenance with Suboxone entails the same substitute-narcotic-dependence from which, eventually, weaning is necessary anyway.

The harmful effects of Suboxone usage or overdose may include the following:

- An allergic reaction such as rashes, hives, swelling of mouth, face, lips or tongue, irritation.
- Slow or shallow breathing.
- Dizziness, confusion, or blurred vision.

• Liver problems such as yellowing of the skin or eyes, dark colored urine, light colored stools, decreased appetite for several days or longer, nausea, or lower stomach pain.

• Constipation or diarrhea.

• Mental or mood changes, including depression.

• Anxiety or nervousness.

• Decreased attention.

• Lack of coordination.

• Nausea or vomiting.

• Severe headache.

• Sleeplessness.

• Fainting.

• Irregular heartbeat.

• Swelling of the hands, ankles, or feet.

This list of Suboxone side effects is by no means exhaustive. An overdose of Suboxone can even cause death.

Social Drawbacks of Narcotic Substitution Maintenance Therapies

Indefinite continuance of maintenance therapies is individualistically suicidal and socially harmful. These narcotic-substitution maintenance therapies are not only incomplete and unsatisfactory on an individual basis, but dangerous for society as a whole. They have not accomplished their initial goal of diminishing the effects of narcotics on the general population.

Methadone's narcotic-substitution therapy was popularized in the 1970s and promoted as a way of getting people off of the erstwhile, predominant narcotic heroin. The experiment has, in that regard, been a failure because heroin addiction has increased over time. The case is similar with Suboxone usage, as we're seeing many addicts becoming dependent on the drug.

Suboxone maintenance, while more convenient than methadone treatment, essentially has the same effect. For the duration of maintenance, the addict remains in the drug world. Ongoing usage of Suboxone is equally detrimental to the interests of society as any other drug.

11. Tapering Phases

Like any journey, the overall success of your detoxification plan is closely related to a solid start. A sound beginning lays a strong foundation for a totally drug-free future. As it is often said: “Well begun is half done.”

This chapter will analyze the phases of detoxification that you can expect to experience when tapering your dosage of Suboxone (or any other replacement drug): the early phase, the middle phase, and the end phase. My goal is to reassure you that your discipline throughout detoxification will prepare you for continued success.

What Is Tapering?

Tapering is the process of gradually reducing the dosage of a medication. Taking a moderately paced approach helps lead patients to a point where they no longer feel like slaves to drugs or that drugs are required for a comfortable existence.

Tapering is an essential part of any drug-recovery schedule and must be carefully planned and monitored. If Suboxone is stopped suddenly, the patient may experience withdrawal symptoms, just as with the original narcotic. Conversely, if a dose is administered before it is due, resulting in an overdose, and fatal side effects can occur.

The Bock Method involves a tailored approach to each patient’s current level of addiction and begins with a Suboxone dosage that is comparable or slightly lower, typically one or half a tablet a day. I work *with* the patient to create a tapering schedule, and together we agree on the plan to lower the dosage over the next two to four months until he or she is off of the drug completely.

It’s important that you, as the patient, make a commitment to stick to the plan, because it’s not always easy. Taking the leap can be scary, but my patients report that the discomfort isn’t terrible. In fact, it’s much easier than the ups and downs experienced on the streets.

The alternative to tapering is years of replacement drug therapy and not sobriety.

If you were to seek out detoxification and subsequent replacement drug therapy, odds are that you would be placed on a long-term treatment protocol that involved years of continued drug use. Doctors and clinics who want to *quickly* help patients achieve *full sobriety* are few and far

between. This is largely because the long-term model works better for clinics and doctors alike, guaranteeing longevity in their "customer base." This doesn't mean that long-term treatment is *never* the right option, especially in the case of those who have been addicted for long periods of time. It simply means long-term treatment should not be the "go to" approach for all addicts.

A finite taper, in nearly all cases, has the patient's best interests in mind, and research shows it works. A study[60] published in 2013 showed that the number of participants who followed a four-week tapering schedule was significantly greater than those who followed shorter regimens. An in-depth literature review[61] on tapering protocols found that "[t]he Mayo Clinic Program uses a gradual, structured taper on a time-contingent basis during three weeks, with rates of completion that can be above 90 percent," which is an impressive statistic.

The Early Phase

The early phase is the most crucial part of the detoxification plan, setting the stage for complete sobriety. The more devoted and dedicated you are in the early phase, the more assured you can be of a timely and long-lasting successful outcome in the end.

The early phase begins the moment you realize that you can no longer bear the damage narcotics are causing in your life. You've decided to take action, and the fire of detoxification has been ignited! This phase is often characterized by promises to change "for good" and to adopt a new, healthy lifestyle across the board.

In this phase, the usage of illegal narcotics is stopped and a substitute drug (like Suboxone) is administered. The withdrawal symptoms are most prominent in the early phase, and you may find yourself irritated and restless and acutely aware of urges to use again.

You may experience mixed feelings at this stage, moving between feelings of anxiety, nervousness, and doubt, and then bouncing back with a feeling of inner pride and relaxation. Focus on the latter and the tinge of euphoria stemming from the exciting possibility of a new, better life. Allow support from family, friends, and your doctor to bolster your spirits. In most cases, the addicted person can work through this early phase, relying on the power of their promises and the olive branch extended by loved ones as treatment gets underway.

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[60] file:///C:/Users/tiffa/OneDrive/Documents/Upwork/Dr%20Bock/4%20week%20taper%20article.pdf
[61] https://www.mayoclinicproceedings.org/action/showPdf?pii=S0025-6196%2815%2900303-1

The Middle Phase

The successful culmination of the early phase leads the way to the middle part of the detoxification, wherein the Suboxone doses are essentially stable, albeit declining slowly. Some addicted people experience a stable and somewhat relaxed middle phase; for others it is rockier as they work through difficult emotions pushed away during narcotic usage. If anxiety is a factor, the addicted person must resist the urge to "fix" the problem by getting high.

This middle stage of detoxification is the most quiescent, with newly clean addicts experiencing a heady combination of commendations and self-satisfaction as they reclaim jobs, relationships, and a place in society. Now, the stress and tension of the first stage are easily forgotten (or at least swept under the rug), and the physical withdrawal symptoms prominent in the early stage have largely diminished.

Unfortunately, many patients face struggles during the middle phase as well. It's at about this time in the process that the initial urge to get clean begins to dissipate and temptation becomes a prominent theme. A lack of family support or involvement in healthy activities can open the door to relapse. In the best cases, however, family and friends are heavily involved and play a significant role in steering you away from poor choices.

Strategies for Success

The middle phase can be best managed by paying attention to certain factors, as described below:

• Do all you can to ensure your environment is calm and soothing. Added stress and chaos can heighten your anxiety and undermine your efforts.

• Stay busy with productive, healthy activities to keep your mind off withdrawal symptoms.

• Implement new habits into your daily routine. Even minor changes like going for a morning walk, chatting with a friend over coffee, or indulging in a hobby like painting or music will help release the strain on your mind.

• Surround yourself with people who are invested in your success and are capable of giving you the support you need.

• Hold yourself accountable for meeting your obligations, even when you don't feel like it.

The End Phase

The end phase marks the final goodbye to drugs. You may find yourself hit hard by the realization that in just a short period of time, you will no longer be prescribed Suboxone and will truly be asked to stand on your own two feet. Over the years, my work with patients has demonstrated that the stress and panic associated with completely eliminating Suboxone doses is more of a psychological phenomenon than a purely physical one. Patients have had doses dropped by quantitatively larger amounts in the first few days of treatment than in the last few weeks—and by larger percentage amounts as well. Nonetheless, there is a nearly universal anxiety that bubbles up when the "end days" draw near.

Some have suggested using a placebo at the very end (final "doses" of Suboxone that contain nothing): designed to preserve an illusion that the treatment continues; that one does not yet need to rely on internal guidance and inner resources. The idea aims to help the patient cross that last psychological threshold without panic. But as a physician, I cannot support it. Informed consent might make it acceptable in a study, but not in personal care. Giving a patient an inert substance , falsely allowing the belief it's active medication breaks the trust we've worked so hard to build. At the moment he most needs to stand on his own, we cannot pretend to hold him up.

When each of my sons learned to ride a bike, I had watched other fathers do their best to help: running beside the bike; holding the seat; offering encouragement. But every father runs out of breath eventually; usually within 50 m; way before the child gets his independent bicycling- "sea legs". The riding child then suddenly notices no one is holding on, and panic sets in.

I took a different approach. I put on inline skates so I could stay with him longer. When he started to get the hang of it, I would take my hand off the seat; but, without his realizing it. He kept riding, steady and unafraid, because 'knowing" I was still holding on. I skated beside him to preserve that belief—not to trick him, but to give him confidence.

That lingering presence meant something. Just as a basketball player might cross himself before a free throw, trusting that something greater still guides him, a child rides more calmly when he feels a parent's presence surrounding him. That reassurance eventually becomes part of him.

In addiction treatment, something like extended-release naltrexone (e.g., Vivitrol) can play that kind of role. It doesn't replace Suboxone, and it doesn't offer a high. It simply stays present: enough to help the patient keep showing up; long enough for confidence to take root. At some point, he sees the truth: the support was already within him. But until then, it helps to believe someone, some power still skates beside him.

A Final Note: Addressing Fear in the End Phase

It is common for patients to feel discomfort and fear when treatment is nearing its end. This feeling can be aptly compared to what a college graduate experiences just before graduating: the fear of the unknown and the weight of new responsibility. There is no perfect way to address this fear of the future, but most concerns can be addressed through proper counseling.

The issues surrounding the end of detoxification are almost entirely psychological during this final stage of the tapering process, causing both anxiety and trepidation. The anxious patient may begin to anticipate the possibility of Suboxone maintenance. The anxiety may be about mild withdrawal symptoms or regarding sleep without narcotics. So, making the patient feel confident and reassured of his sobriety becomes a challenging task and an additional responsibility for all concerned: family, friends, and the doctor.

12. Passing the Test

Regular and unannounced drug tests are part of any legitimate treatment regime. They serve to hold you accountable for your commitment to sobriety by testing for opiates and a host of other substances. Drug testing also enforces the ideal of sobriety by disallowing the use of Suboxone treatment as a temporary, cost-cutting strategy to get high. If you have adhered to the standards agreed upon by you and your physician, you are certain to pass any drug test.

Many addicts fool themselves into thinking that alcohol, amphetamines, tranquilizers, or marijuana are not drugs *per se*, or at least are not problematic drugs for themselves. In fact, nearly all narcotic drug issues can be traced (backwards) to initial use of these other substances, and certainly this path back to narcotics can be recreated if your guard is let down.

What Is a Drug Test?

A drug test is a technical analysis of biological specimens, such as urine, blood, hair, or saliva, that checks for the presence or absence of certain narcotic drugs or other mind and mood altering substances. Testing is done by a trained technician in a well-equipped laboratory.

Depending on the drug(s) used, frequency of use, quantity consumed, overall health of the patient, and methodology used for testing, a drug can be detected for a period up to three months after ingestion. So, testing is an effective way to check the consumption of drugs, and if a positive result is yielded, to devise a plan to tackle the situation accordingly.

The benefits of drug testing are immense. Let’s have a quick look:

• Drug testing helps in confirming suspicions of possible drug use by recovering addicts.

• It aids in developing a framework of rules and consequences for the erring addict who fails to pass the test.

• Testing helps prevent the “casual approach” toward the whole endeavor and ensures whole-hearted attempts at recovery.

• The anticipation of drug testing promotes higher levels of achievement among participants.

• Regular testing decreases the chances of relapse considerably.

• The tendency to take refuge in substitute drugs like Suboxone is reduced.

• With testing, one can rest assured that the detox plan is moving in the right direction.

Why Testing Matters

Just as many college students would admit to not studying material for which there was no exam, a recovering addict is not very likely to adhere to sobriety if there is no measuring stick. As such, a detoxification plan without adequate testing would be akin to going on a wild goose chase, a meaningless journey devoid of any destination. After all, what is detoxification without the elimination of addictive substances? Similarly, what then would be a detoxification program without drug testing?

Like any effective discipline strategy, the inclusion of drug tests in a treatment program has a positive reinforcement element. When you pass a drug test, it's a moment to take pride in and should serve as a motivation to stay clean until the next test. Your confidence should grow with each passed test, and eventually, what seemed nearly impossible in the beginning is easily achievable.

What if You Fail the Test?

Failure of drug tests is not uncommon; when this happens, it is time to look back and analyze so corrective action can be taken. This includes any needed counseling and any agreed upon consequences, which should have been established at the onset of treatment.

13. Relapse Is Not a Part of Recovery!

I'm frequently asked if relapse is a normal part of recovery. From my perspective, the obvious answer is "no." How could returning to drug use be considered a "normal" part of your attempt to get clean? The recovery process is indeed a bumpy road, filled with stumbles, uphill treks, and of course, those wonderful moments of peace. Each step on the journey, whether backward or forward, is part of the process, and even a relapse, akin to leaving the road entirely, should not deter you from pushing ahead with all your might. This does *not* mean, however, that you should view relapse as an acceptable and expected part of your recovery. It is, in every sense of the word, a pitfall, and should be avoided at all costs.

What Is a Relapse?

Relapse occurs when a patient who has begun the recovery process starts using again. Your drug addiction may lead to such a strong, uncontrollable, and compulsive drug craving that you have severe difficulty giving up its use even though you're aware of the harsh consequences. For some, drug addiction can become a chronic problem even *after* long phases of abstinence.

It's important that you are both aware of your progress thus far and humbled by the possibility that it can all be taken away with a self-defeating choice. Succumbing to relapse is often a spur of the moment decision, but the fallout inevitably lasts much longer. Consider these examples:

• Getting a tattoo takes considerably less time than having it removed.

• In less than a minute, an earthquake can destroy buildings that took years to build.

• An accident on a busy highway occurs in an instant, but the injuries sustained by those involved may take weeks, or even months, to heal.

In understanding the relevance of these examples, you should begin to see your life as a valuable commodity, not to be risked for a few moments of "pleasure."

Why Do Relapses Happen?

The most common reason for relapse to occur is the inability to cope with the withdrawal symptoms that grip your body. There may be terrible pain, irritation, indigestion, sleep disorders, and mood swings. Sometimes, you feel so helpless that relapse seems to be the only refuge to feel at ease.

People who relapse usually do so because they accepted the things they could have changed.

Another reason may be the company of so-called friends who are addicts. They may pressure you to have "just a little" and give you a hard time, perhaps even calling you a "prude" if you say no. If you don't possess the iron will needed to refuse, you're likely to relapse in this type of social situation. Criticism from sober friends and family may also make you more susceptible to relapse. If you feel everyone is against you or quietly talking amongst themselves about your former misdeeds, you may very well feel mentally broken and supremely irritated. As a result, you might decide your recovery efforts are pointless and experience an urge to shun everyone and return to the comfort of drugs.

Other common triggers like anxiety, sleeplessness, mental strain, and boredom can also result in a misstep that leads to relapse.

Excuses, Excuses, and More Useless Excuses…

You may have prepared a list of carefully contrived reasons to justify a relapse. Without exception, these are no more than mere excuses. The truth is, excuses never serve any purpose other than lowering your self-esteem. By making excuses you are cheating yourself out of a fulfilling, sober life. So, rather than justifying a potential or actual relapse, accept your failure heartily and pledge not to let it happen again (or at all). Returning to drug-usage is a bad choice made by *you,* and no excuse is valid.

What to Do if You Have a Relapse

Despite all the precautions you have in place to prevent relapse, the possibility of it occurring can't be totally ruled out. Thankfully, there are tools that can be utilized to help you quickly

recover and get back on track.

First, it is crucial to understand the trigger that led to relapse. As discussed, common triggers include anxiety, sleep issues, boredom, irresponsible use of extra money, real or imagined pain, contact with negative peer groups, and letting one's guard down (false confidence). Addressing the root cause of the trigger that prompted your relapse can help prevent it from happening again and will serve as a reminder of the personal responsibility you carry in regard to your successful recovery.

Here's your Top Ten list of strategies to help prevent relapse from recurring (or, ideally, occurring in the first place):

1. Don't consider relapse a normal part of recovery. Stand firmly against it.
2. Use simple relapse prevention tools such as socializing with sober friends, joining voluntary organizations, seeking employment, and spending time in nature.
3. Restrict your access to bank accounts, money, credit cards, and other valuables.
4. Hold yourself 100 percent responsible for your decisions. No excuse is valid.
5. End negative friendships with people who encourage you to use drugs.
6. Seek your physician's advice immediately. Consider visiting a psychologist or purchasing self-help books.
7. Try to relax by healthy means such as yoga, meditation, aerobics etc.
8. Plan drug-free trips or excursions with your family.
9. Learn and repeat positive affirmations to bolster your self-confidence.
10. Ask your family members and friends to keep close watch over you. Remember, too much freedom at this stage can backfire.

14. Strategies for Success

Part 2 of *Withdraw to Freedom* has been largely concerned with explaining your options, the detoxification process, and the Bock Method of attaining true sobriety. These final chapters of Part 2 serve as a playbook of sorts, reminding you of strategies for success that have appeared in other chapters and illustrating new ideas to help you achieve your goal.

Keep in mind that *freedom* is a greatly hyped but often misunderstood concept. Freedom, in your case, is not the license to do anything you want. It is, rather, the highest degree of self-control manifested in making positive, healthy decisions for yourself. Making the transition from the thought patterns of narcotic dependence to the sometimes frightening freedom of a drug-free life with its greater panoply of choices can be overwhelming, but what lies ahead is undoubtedly a life worth living.

Post-Detoxification Goals

Here is a short list of goals you should strive for in the weeks and months following your detoxification. Add to this list any more ideas that suit your personal needs.

- Maintain sobriety by any means.
- Attend all doctor appointments.
- Terminate negative friendships that may reconnect you to the drug regime.
- Seek and secure a job.
- Discharge your debts at the earliest.
- Complete your daily responsibilities without any help from others.
- Adjust back into “normal” society.
- Re-establish meaningful connections with family and friends.
- Work on rejuvenating your immune system by eating healthy and taking care of your body.
- Avoid the pitfalls of depression by taking on new activities like yoga, meditation, reading self-help books, and learning deep breathing techniques.

Success Is Not a One-Stop Shop

There is no shortage of strategies you can put in place to help you succeed. Each of the following sections can play a role helping you overcome cravings and temptations as you put your days of drug use behind you.

Continue Therapy

Newly sober patients should seek out continued therapy to support their ongoing journey. There are a variety of outpatient mental health services offered for recovered addicts. Make use of the web to locate and review therapists in your area. Making a weekly appointment to talk to an addiction therapist helps hold you accountable and gives you something to look forward to each week. It also provides a safe space to share any concerns, doubts, or challenges you are experiencing.

Bid Adieu to the Regime of Drugs

Say goodbye, for good, to the hellish world of addiction by walking away from it and never looking back. Cut all ties with drug dealers and friends who use *immediately.* I recommend changing your phone number and clearing out your social media accounts without any formal acknowledgement of doing so. Block anyone who was part of your old life. Avoid people, places, and situations conducive to and tolerant of drug use. There are much better people to share your life with and better places to make new memories.

Seek Gainful Employment

Being employed will help you stay busy and allow you to contribute to the welfare of your family. If you don't have a family to support, you can use your income to begin paying off debts and building a future for yourself. Working will also boost your confidence as you increasingly feel like a productive member of society. Seek a job that has plenty of hours for you, and work as much as possible!

If you're considering going back to school or working in an industry that requires training or certifications, this is a great goal, but not one that you should focus on immediately. Work for six

to twelve months first to establish your sobriety and prove that you are ready to take on a new responsibility.

Mind and Body Fitness

Leading a healthy lifestyle can be a determining factor for establishing a drug-free existence. To ensure a healthy mind and body, you must pay heed to the following aspects:

Regular exercise. Exercising builds up the strength and stamina of your body, which had been severely hampered due to drugs. It also releases those "feel good" endorphins that help alleviate symptoms of anxiety and depression. Anything from walking, swimming, and jogging to a game of tennis or going for a bike ride is a step in the right direction.

Maintaining a balanced diet. A good diet is the basis of good health for an ordinary person and even more so for a recovering addict. It is required to boost up the immune system of the body. Focus on eating whole foods and incorporating fruits and vegetables into your daily meals. Stay away from sugary foods and drinks, like processed snack cakes and soda.

Positive thinking. If you think you can, then you *can*. Fill your mind with optimistic and positive thoughts. You can do this!

Get plenty of undisturbed sleep. Sound sleep is essential to refresh oneself after a hectic day. It replenishes your energy and gives you the stamina to take on the problems of the next day. At bedtime, turn off your TV and computer, and put away your electronics. Do not go on social media. Do not look at funny cat videos. Do not check with Facebook to see what your former druggie friends are doing. *Just go to sleep*.

Indulge your hobbies and passions. Think about something you enjoyed doing before your addiction took over, or something you always planned to do but let fall by the wayside, and do it! Take those piano lessons, learn to skydive, get your scuba diving certification, or learn how to dance. Engaging in healthy hobbies will give you a sense of satisfaction and achievement while also helping you unwind and relieve stress.

Combat cravings. As you know, drugs are habit forming chemicals that cause physical and psychological addiction, and kicking addiction to the curb is no easy feat. Even after detoxification and completion of your program, you may, at times, feel tempted to go down that forbidden path. This compulsive desire or craving for drugs is tough to resist.

Simple tricks will help you resist the craving:

• **Deep breathing and relaxation exercises** will help you gain self-control so you can handle cravings by relieving tension and anxiety.

• **Meditation** allows you to reflect on positive thoughts, cope with stress, and gain patience.

• **Keeping yourself busy** means your mind will be occupied with healthy activities and obligations, so you will have little time to consider drugs.

• **Thinking the entire scenario through** helps you paint a realistic picture of what drug use did to your body, mind, and life—and will certainly do again if you relapse. This is a powerful motivator to stay clean.

• **Reading motivational literature** helps you view life from a different perspective that you may not have arrived at on your own.

• **Learning a new skill or art form** helps make your life more meaningful and adds depth to your self-perception.

Indulge in hobbies and passions. Activities like singing, dancing, painting, swimming, book reading, photography, etc. provide mental relaxation. It can be an activity that you are already familiar with or something completely new. Hobbies will help you unwind and get relief from stress associated with detoxification.

Lean on your family and friends. Attaining sobriety is hard. You can achieve success with the help of your doctor alone, but your odds of success substantially increase if your family and friends are ready to support you. Don't be shy about reaching out to people you trust, especially in moments of weakness or temptation. Chances are, those who love you and care about your well-being are more than happy to help you in any way they can.

Faith

This section of the book is dedicated to religious or spiritual faith as it pertains to a higher power, however you define it. If you don't want to participate in this discussion, feel free to move forward to the next chapter, but I encourage you to open your mind to the ideas herein.

As an addicted person entering recovery, it can be tremendously helpful to discover and explore both faith (which is emblematic of your own spiritual journey) and religion (which is the conjoining of your own faith with others).

Over the years I've heard hundreds of addicts explain their having gotten into drug usage by

"hanging with the wrong crowd." Let's flip that concept on its head. It could be that getting *out* from under the burden of narcotics involves "hanging with the right crowd." And where better to look than in a place where people have come together to follow their spirits' best tendencies and hopes, and where people yearn to help each other and stay away from pathways that lead to ruin?

Some addiction professionals avoid discussions of faith in their practice because they fear offending those who are not religious. Others don't include faith as part of their programs because they themselves do not subscribe to any particular version of faith. My personal experience with addicts has shown me that many people just beginning recovery are eager to consider expanding their own innate faith, strengthening it through religion, and beginning a personal and spiritual reclamation: to get back their real selves—in effect, their souls. Having the approval, the community, and the help that comes with religious organizations can help recently ex-addicts invest themselves with the continuity of purpose needed for any great accomplishment.

Many of the addiction treatment professionals who can't or won't encourage any exploration of your religious spirit in fact do recommend religion, but not necessarily of the standard church or congregation variety. They recommend AA and NA, each of which are very close analogues to religion.

Will reference https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043382/ e g In a study of U.S. high school seniors, researchers found that religious students were least likely to engage in at-risk behavior and that religiosity was the most powerful predictor of at-risk behavior (Benson & Donahue, 1989).

A Divine Power

In your endeavor to escape the self-destructive world of addiction, faith is a mighty companion. Different aspects of faith such as faith in one's abilities or faith in God's supreme power are equally important during detoxification and recovery. It not only helps you overcome challenges but also facilitates the development of healthy and long-lasting relationships.

Faith is a belief in something, without doubt and without evidence.

Organized Worship

Organized worship holds many benefits, including the opportunity to have meaningful conversations with mainstream, functioning people. Some may be reluctant or intimidated to join or rejoin church because of past transgressions, or lack of experience in such communities. Many of the addicted people I've worked with have reported a decline in stress levels upon attending regular church services.

The Need for Positive Guidance

Many addicted people come from fractured families where guidance is scarce, inappropriate, or missing. It is a simple truth that people, especially children, need positive guidance. That guidance is readily and gladly available in churches and temples. A church is a place where you can unwind yourself, confess your misdeeds fearlessly, ask for forgiveness, and rest assured that it shall be granted. How often you can expect that in a family (except in a very close knit one)?

The morning prayers and ceremonies at church or temples soothe your bruised soul. You tend to feel a kind of relaxation and rejuvenation.

God is omnipotent and omnipresent. He is our true companion, friend, philosopher and guide. Like a loving parent, he is always there to care for us and nurture us. So, whenever you find yourself in a fix and life seems to be slipping off your grip, just remember him and move on His path. All the doubts will then vanish like a bubble and your decision to come out of addiction will be reinforced.

Faith and Recovery: The Link Investigated

Now, a crucial question arises: Is faith a prerequisite to recovery?

This chapter does not claim faith as a prerequisite for recovery, but well worth investigating; especially as contrast to the *lack* of faith that accompanies, almost always, deep addiction and drug-dependency. Faith is helpful during the challenges of early recovery. The positive community found in faith can help in forming or renewing healthy relationships with community and family. When you have faith, your morale is high. You feel yourself capable of doing everything.

15. Narcotics and Your Money

Now that you are well-informed about the process of detoxification and the amount of commitment and work it takes to attain sobriety, I want to offer a very concrete reason to move forward with your desire to get clean: money.

This chapter is designed to help you see the truth about how much money you're spending on your habit and how easily you can turn things around if you're committed to change. Narcotics of any kind cost money—a lot of money. Whether you've stopped to think about it or not, the money you've thrown away on drugs has undoubtedly had a destructive effect on your sense of self-worth. Have you been unable to pay a utility bill or rent/mortgage payment? Have you eaten cereal for dinner because you couldn't afford an actual meal? Have your children or spouse gone without something they needed? Acknowledging that your narcotic addiction has wreaked havoc on your financial life can fuel your motivation to get clean, so it's important that you take an honest look at this aspect of your addiction.

Beyond admitting how much you've spent on narcotics, the reality that your addiction has very likely hurt your ability to make a living is another significant factor. As such, understanding the purchasing power you will have once you get clean can be another inspirational tool for staying sober. Envisioning the rewards of returning to a steady, legal job is the beginning of building a positive outlook for the future.

This chapter shows you how to mend the financial mistakes you've made and provides a set of tools for establishing a secure, drug-free financial future.

Your Money and Your Addiction

Narcotic use has perhaps become such a routine part of your life that you have never stopped to figure out exactly how much money you're spending on drugs. Whether you're buying heroin, Oxycontin, fentanyl, methadone, or something else, money spent in this way adds no value to your life; in fact, it has a tangibly negative effect. This is an opportunity to find out how much it's really costing you.

The average heroin addict spends $150 per day on drugs[62]. People heavily addicted to Oxycontin or fentanyl can spend $40 to $80 *per pill*[6364]. Methadone, when purchased illegally, can cost $50 to $60 per day, or more. Prescribed methadone treatment is not quite as hard on your wallet, but it is still costly. Clinics typically charge $126 per week[65] (this can be less if clinic visits are not daily).

If you fall into one of these categories, take a look at the charts below, pinpoint which line applies to you, and circle it (yes, really pull out a pen and circle it in the book). *Costs shown are approximations.*

Cost of heroin use

$ PER DAY	$ PER WEEK	$ PER MONTH	$ PER YEAR
$50	**$350**	**$1,500**	**$18,250**
$100	**$700**	**$3,000**	**$36,500**
$150	**$1,050**	**$4,500**	**$54,750**
$200	**$1,400**	**$6,000**	**$73,000**

Cost of Oxycontin use

**Fentanyl usage to achieve a similar high is approximately the same as Oxycontin*

Amount used per day	$ PER DAY	$ PER WEEK	$ PER MONTH	$ PER YEAR
80 mg	**$92**	**$644**	**$2,760**	**$33,580**

[62] https://drugabuse.com/the-price-tag-of-heroin-in-america-51-billion/
[63] https://drugfree.org/learn/drug-and-alcohol-news/sky-high-prices-for-prescription-opioids-sold-on-street/
[64] https://www.addictioncenter.com/drugs/how-much-do-drugs-cost/
[65] https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/how-much-does-opioid-treatment-cost

160 mg	**$184**	**$1,288**	**$5,520**	**$67,160**
320 mg	**$368**	**$2,576**	**$11,040**	**$134,320**
400 mg	**$460**	**$3,220**	**$13,800**	**$167,900**

Cost of illegal methadone use:

$ PER WEEK	**$ PER MONTH**	**$ PER YEAR**
$60	**$257**	**$3,120**

Cost of prescribed methadone treatment:

$ PER WEEK	**$ PER MONTH**	**$ PER YEAR**
$126	**$504**	**$6,550**

As you can see, drugs are expensive. Even a seemingly affordable methadone maintenance program might be costing you upwards of $6,000 per year, which could be six months of rent or mortgage checks. Hopefully, these charts opened your eyes in a big way.

Narcotic Abuse Effects on Income

Are you currently working at good job? If the answer is “yes,” you can skip this section. If not, keep reading.

First, face reality. Did you lose your job after performing poorly or missing work because you were high? Are narcotics (and your efforts to obtain them) sapping your energy and motivation, keeping you from getting back out into the workforce?

Let's evaluate what drugs have cost you, in addition to their actual cost. If you lost a salaried position, you know how much you lost per month. Write that into the box provided below. If you lost an hourly wage job, take a look at the chart below and figure out the money you could be making if you were rehired for a similar position. Circle the line that applies most closely to you. If you've never worked, circle $10 per hour.

Cost of Job Loss (Salaried)

$ per month

Cost of Job Loss or Inability to Work (Hourly)

Hourly Wage	**$ per month (part-time/20 hours per week)**	**$ per month (full-time/40 hours per week)**
$8	**$640**	**$1,280**
$10	**$800**	**$1,600**
$15	**$1,200**	**$2,400**
$20	**$1,600**	**$3,200**

Even though a lost job doesn't appear to hurt the wallet as much as the cost of drugs themselves, it still hurts.

Another thing to consider while examining the cost of your addiction is the effect a criminal record can have on your financial future. Possession of opiates, selling them, and/or driving under the influence are all illegal activities that can land you in jail. A conviction for

narcotics-related activity on your record will make finding a decent-paying job difficult down the road (and you can't work while you're in jail). If you haven't yet had run-ins with the law, let this be the inspiration for you to quit while you're ahead.

This isn't a lecture about crime and morality. It's a matter of economics. Ongoing drug use definitely breaks the bank, and if it leads to an arrest and jail time, the amount of money you'll lose over your lifetime can be astronomical.

If you have stolen, hustled, or engaged in prostitution to support your habit, try to wrap your head around the following. Good lawyers cost money and, if you end up in jail, it will be impossible to earn cash you need to pay one. Dealing drugs also exposes you to an industry where violence is part of the status quo. Even if you have a "life is dangerous" mentality, you might want to consider who is going to support your children if you're dead. Don't have children? Then ask yourself who is going to carry your parents through their final years. It's pretty doubtful you're going to turn into a filthy rich drug kingpin like you've seen in the movies. If you're under the impression you're going down this road, you might want to take a look in the mirror and ask if you're deluding yourself. The truth is that you can make just as much money through a legitimate employer, working the same amount of hours, without the risk of being beat up, arrested, or shot.

If you have never taken the time to acknowledge what your addiction is doing to your finances, seeing it in black and white might be very upsetting. But take heart: the first step toward finding a solution is gaining a better understanding of the problem. If you've picked up this book, it's because, on some level, you want to get and stay clean. *It is crucial* that you take off those rose-colored glasses and accept responsibility for your behavior and its consequences. What you learn by doing so can serve as lasting motivation for success.

Imagining a Clean Future

What would your life be like if you could redirect all the time and money you spend on drugs into more productive areas of life? All that money will go into your bank account so you can decide what type of lifestyle you want to live now and in the future. Instead of drugs dictating whether you live on someone's couch or in your own apartment or home, you get to choose. Instead of drugs deciding that you'll have to work into your seventies or eighties, you can choose

to put money away for your retirement. When it's time to purchase a new jacket, gaming console, or car, drugs won't stand in your way. When you free your wallet from the clutches of drug use, the possibilities are endless.

I want to tell you about a former patient of mine, Alan. He is a success story that could have easily spiraled in a different direction.

In his early twenties, Alan's grandmother died and left him a small nest egg. He had a job working construction and the future looked bright; in fact, he had plans to get his independent contractor license to move up in the industry. Alan married his wife Sarah when he was twenty-seven, and within four years they had two small children.

Then things took a turn for the worse. The 2008 Great Recession hit the construction industry hard, and Alan's work hours were reduced from over forty to just twenty per week. Feeling down and helpless, he filled his extra time by hanging around with some old buddies from high school who were into taking Oxycontin recreationally. What started as a "fun night out" quickly turned into a daily habit. Before he knew it, he was taking 160 milligrams just to feel sufficiently numb.

Despite the haze brought about by his addiction, Alan saw that his family life was falling to pieces. Sarah, a teacher, was worried about recent budget cuts at her school and feared losing her job—and the family's health insurance. When she said she was glad they had a decent savings account, Alan knew he was in trouble. He'd been withdrawing nearly $1,000 a month to keep up with his new habit, and the savings account had dwindled, substantially.

Thankfully, this was a wake-up call for Alan to seek help and break his addiction. After just a few months of treatment, he was able to revive his work ethic, and rather than hanging out with his druggie buddies, he began seeking out side jobs to supplement his part-time hours at work. Over time, he was able to replace what he'd taken out of the savings account and doing so bolstered his confidence to stay clean. The vision of his success, combined with the knowledge that his children and wife were being provided for, played a huge role in Alan's ongoing recovery.

Your life might be similar to Alan's, or it might look completely different. Either way, breaking free from narcotics addiction or methadone dependency will almost certainly improve your financial prospects.

Using Goals as Inspiration

Setting realistic goals can serve as a huge source of inspiration on your journey to eliminate drugs from your life. Think of something you've always wanted: a certain car or motorcycle, a vacation to a luxurious island, or a whole house Wi-Fi speaker system, for example. Choose something from your wish list that's attainable within a six- to twelve-month time frame, given the money you'll be saving by not buying drugs *and* your earning potential as a sober individual.

Write this goal down on a sticky note and wrap it around your debit card. Put it on an index card and tape it to your refrigerator, your bathroom mirror, your front door, the dashboard of your car. The idea is to come face-to-face with your goal all day long so you are reminded of the reward that's waiting for you! You're going to have to walk out the front door, right past your goal, to go see your dealer. If you've taped it on your steering wheel, it's going to be hard to ignore on your way to buy drugs. When you pull out your ATM card to get some cash, the goal is going to jump out of your wallet along with it. The point is to have the goal "wake you up" right before or during the first steps in the process of buying drugs. It is to help you realize that you haven't done the deed yet, and that you still have the opportunity to stop. You may even want to add an inspirational question to your goal: "Can I achieve this if I buy drugs?" The answer, of course, is "no." If you stop to focus on that for even half a minute, it can go a long way toward strengthening your will so that you can halt the drug-buying process.

This process can help carry you through the process of getting clean and *staying clean*. If you were heavily using and recently underwent a physical detox treatment, you understand that you're not really out of the woods yet. Physical dependency is only one aspect of drug addiction. Old habits and familiar cravings consistently try to break down your will. This is a challenge all recovering addicts face. They go through detox and stop "using," so they're "clean" physically speaking, but old coping mechanisms and rationalizations can sneak back into their thoughts. The recovering addict easily forgets the bright promise of a drug-free future and surrenders to "just this once" or "I need it after a day like this."

Beyond setting a goal for inspiration, you should also look more closely at the steps you take to purchase drugs and think of ways to interrupt those steps. These tips will help.

Don't Keep Cash Around the House

If you don't have a checking account (or don't use the one you have), get one and use it. If you're working, have your employer use direct deposit so that funds go directly into your account. Dealers don't run plastic, so keeping the cash in your wallet to a minimum is important. Use your debit card to pay for everything. If you do initially fall prey to a craving and walk out the door to withdraw cash, the drive to the ATM will at least give you some precious time to reflect on your behavior—and hopefully, you've stuck a copy of your goal right on top of the card in your wallet. Stop, think, and visualize: remind yourself where you really want your money to go.

Ask a Trusted Loved One For Help

If you have a long-term partner, family member, or very close friend *who is not a narcotics user*, you could work out a system where they hold your ATM card or have control of your savings. Sit down together and go over how much money you need for living expenses every month or week, put it on paper, and affirm to them that you only want that amount. Establish guidelines: if you approach them in an obsessive mood, asking suddenly for your card or extra cash, it's a red flag. If this happens, you'll have to either admit what's happening or come up with an excuse and lie to them. Hopefully, it will be harder for you to do the latter. It will be easier to push aside guilty feelings when you're looking at an ATM screen than when you're facing your father, wife, brother, or sister.

Obviously, you must trust the person with whom you decide to do this. And you both must understand from the beginning that it could result in some intense emotional situations. But if a loved one has stuck with you through the worst part of your addiction, chances are they will be willing to endure this too, as he or she is playing a role in helping you stay away from narcotics.

Ultimately, whichever of the above methods you choose, it's important to remember something: **It all comes down to YOU**. The tips I've provided work because even though your cravings are intense, they *only last for a limited period of time*. Putting safeguards in place buys you time to talk yourself out of trouble, but the tools don't do all the work themselves: you have to apply your own effort and will. You must pursue your goal of staying clean actively, with

intent and attention. Keep in mind that your loved one isn't there to regulate your behavior; he or she is there to buy you a bit more time so you can tap into the best part of yourself and apply restraint. Each time you stop yourself from stepping over the edge, your confidence and willpower will grow. One day soon you will move beyond these more difficult days, confidently managing your finances independently and making your goal a reality.

Breaking Other Dependencies

If you're undergoing a methadone treatment program, you've already come a long way from when you were addicted to heroin or other narcotics. You've taken the first step of acknowledging your problem and sought treatment. But if you're in a multi-year treatment program, you may feel stuck in a rut. This is particularly true if you're paying for your own methadone (and the gas to drive to the clinic) because you're still shelling out money as a result of your past drug addiction. Remain cognizant of the fact that you are not engaged in illegal drug use anymore, and that's what's most important. Then, let the fact that methadone is draining your wallet inspire you to take yourself one step further. Find a doctor, counselor, or group whose philosophy involves reducing methadone intake to zero.

If you are not paying for your own methadone, you may want to consider this: somebody else is. Look back at the "per year" cost of this treatment. If Medicaid or a similar state-aid program is paying this cost, that money is coming from fellow taxpayers. This topic is inevitably sensitive and can make people feel instantly defensive, but it's important to take a balanced look at the situation. The past is the past, and you meant no harm by seeking treatment. But now you're back on your feet and more aware than ever of the costs involved in getting clean. If you've ever earned a paycheck, you know the feeling of having ten, twenty, or even thirty percent skimmed off your earnings for taxes. Now, put yourself in the shoes of others. Would you want your hard-earned money going toward someone's recovery if that person had not set a clear goal for reducing their methadone intake to zero?

Your period of addiction may have left you unemployed, reducing your earnings to zero and leaving your confidence in the gutter. Perhaps you've established a lifestyle supported by welfare, food stamps, and other forms of state-based aid. Again, let's throw the defensiveness out the window for now. The cost to other taxpayers is worth noting, but the greater cost may be the

incalculable toll this lifestyle is having on your confidence and sense of self-worth. The feeling that comes with supporting yourself and, if it applies, your family, is one of peace, strength, and empowerment, and the more passive approach to a life engendered by government support may be doing more damage than you're aware of. If you're in this position, I recommend your first goal is to become self-sustaining, something you can achieve by getting back into the workforce.

Stand Tall and Stay Positive!

People addicted to narcotics come in all shapes and sizes. Some can maintain their addiction while still working in socially esteemed industries and raising a family. Others may have never worked or made a mess of things with a previous employer when their addiction spiraled out of control. Perhaps you fall somewhere in between. Regardless of where you are on this spectrum, this chapter has been designed to help you clearly envision the benefits of a financial future once you've gotten clean and started taking responsibility for your sobriety. Defining your goals is the first step towards reaching them. So even in your darkest moments, remember: a bright financial future is possible.

Appendix 1: The Myth of Methadone

Long-term methadone maintenance treatment has become the most widely used protocol for opiate addiction in the United States. Originally implemented in the 1970s to curb the surge of heroin use, methadone was heralded as a way to reduce drug-related crime and health risks. However, over time, this treatment has shifted from a temporary solution to a system of indefinite maintenance, often leaving patients dependent and without a true path to recovery.

The Myth of Methadone

Methadone itself is not inherently a problem. It is a synthetic narcotic, part of the opiate family, designed to mitigate withdrawal symptoms and reduce cravings. However, the myth lies in how it is used. Methadone is portrayed as a bridge to recovery, but in practice, it frequently functions as a substitute addiction. Patients who switch from heroin to methadone remain addicted to a narcotic. The drug's long half-life and intense withdrawal symptoms make tapering off methadone extraordinarily difficult, often leading to prolonged dependency.

Methadone's origins trace back to the late 1930s and its introduction as a treatment for heroin addiction in the 1960s and 1970s. It was seen as a solution to reduce street crime driven by heroin addicts' need to fund their habits. Proponents believed methadone could stabilize users by eliminating the need for risky, illicit drug use. However, the system that developed around methadone focused less on recovery and more on indefinite maintenance.

Systemic Flaws and Patient Perspectives

Patients often describe frustrating experiences with methadone clinics. Many report that requests to lower their dose are met with resistance. One patient shared:

> *"I kept requesting that my dose be lowered, but the clinic refused and wanted to raise it instead. They thought I was going to relapse if I wanted to taper, but I just wanted to quit the methadone."*

This lack of flexibility undermines patient autonomy and fosters a sense of hopelessness. Patients find themselves in a system that prioritizes daily dosing and compliance over genuine recovery. Methadone clinics often expose patients to environments where drug diversion and street sales are common.

The persistence of methadone maintenance can be attributed to systemic flaws, including financial incentives. Clinics benefit from repeat visits funded by government programs like Medicaid and Medicare, creating a model where neither patients nor providers are fully accountable for achieving recovery. In some cases, patients cycle through multiple detox programs, sometimes a dozen times within a single year, each funded by taxpayer dollars.

The Historical Context of Opiate Addiction

Methadone is part of a long history of opiate use and addiction. From ancient Mesopotamia, where opium was known as the "Joy Plant," to its spread across civilizations, opiates have been sought for their euphoric and pain-relieving properties. In the 19th century, pharmaceutical companies capitalized on the demand for opiates by producing derivatives such as morphine and heroin. Initially marketed as non-addictive remedies, these drugs quickly led to widespread addiction.

In the mid-20th century, heroin addiction became a major political issue in the United States, prompting initiatives like methadone maintenance. Researchers like Vincent Dole promoted methadone as a way to curb heroin-related crime and disease, despite limited evidence on its long-term effectiveness in achieving sobriety. Methadone clinics proliferated nationwide, supported by politicians and pharmaceutical interests.

The Reality of Methadone Maintenance

While methadone has helped reduce some public health risks, such as the spread of HIV and hepatitis, it has not proven effective in helping most patients achieve full recovery. Critics argue that the system perpetuates dependency, with clinics' prioritizing financial stability over patient health. Key concerns include:

- Methadone maintenance explicitly endorses ongoing narcotic use through medical coverage and state subsidies.
- Clinics foster environments where diversion and street sales of methadone are common.
- Daily clinic attendance imposes significant opportunity costs, such as lost employment.
- The rise of dual diagnoses (e.g., addiction and bipolar disorder) is often exploited to secure better payment for services.
- Patients experience passivity and hopelessness, trapped in a cycle of indefinite treatment.

The Need for Reform

Methadone treatment must shift from indefinite maintenance to a recovery-focused approach. Programs should emphasize gradual tapering (the Bock Method), individualized care, and integration into sobriety-based support systems, such as those modeled after Alcoholics Anonymous. Patients need structured plans that promote personal responsibility, employment, and social reintegration.

For methadone programs to truly support recovery, both the treatment community and society must demand greater accountability. Methadone should be one tool among many in a comprehensive strategy to combat addiction. Without systemic changes, the revolving door of dependency will continue to harm individuals and drain public resources.

Methadone maintenance was intended to reduce the harms of heroin addiction, but it has become a permanent fix that often prevents true recovery. It is time to challenge the myth that methadone is the best solution for opiate addiction. Patients deserve a pathway to sobriety that restores their independence, health, and dignity. Addressing the systemic flaws in methadone treatment is essential if we are to break the cycle of dependency and offer real hope for recovery.

Appendix 2: The Suboxone Symbiosis

Following in the footsteps of methadone, Suboxone (buprenorphine) was introduced as part of the 2000 Drug Abuse Treatment Act (DATA) with the promise of its being a more dignified, less stigmatized alternative for opioid addiction treatment. Unlike methadone, which required patients to visit specialized clinics, Suboxone was designed to be dispensed in medical offices, offering greater convenience, decreased stigma, and reduced visibility of addiction treatment. However, this shift has created its own complex web of dependency, incentives, and systemic flaws—a symbiosis between patients and providers that perpetuates opioid dependency in new ways.

Suboxone: A "Safer" Alternative?

Suboxone has been lauded for its reduced overdose potential compared to methadone. It is less likely to cause respiratory depression and is designed with naloxone to prevent misuse by injection. These characteristics have earned Suboxone a reputation as a safer, more manageable treatment option. However, at its core, Suboxone is still a narcotic. It maintains dependency, often with its own set of withdrawal challenges. Patients experience prolonged discomfort when tapering off Suboxone, and many remain on maintenance doses for years.

The initial goal of Suboxone was to help patients transition from dependency to full recovery. Yet, similar to methadone, Suboxone has become a long-term maintenance drug rather than a pathway to sobriety. The rapid rise in Suboxone use—from zero to over 1.4 million users within two decades—mirrors methadone's institutional growth, without significant reductions in overall opioid dependency -- in fact, the opposite.

The Moral Hazard of "Harm Reduction"

The introduction of Suboxone reflects a broader trend in addiction treatment known as harm reduction. This approach aims to minimize the immediate risks of drug use rather than achieving abstinence. While this philosophy has merits in preventing overdose and disease transmission, it

also introduces a moral hazard: the easier it becomes to manage addiction through medicalized dependency, the less motivation patients may have to pursue full recovery.

In essence, Suboxone provides what many patients want at a given moment—relief from withdrawal and access to a legal opioid—without demanding the hard work of rebuilding their lives. True recovery involves achieving independence, much like the process of personal growth in other areas of life. It requires patients to develop their capacities in the "Five F's": Faith, Finances (work), Family, Friends, and (only lastly) Fun. This journey is challenging but ultimately more rewarding than the comfort of perpetual maintenance.

Consider the analogy of a lion or tiger in captivity. In a zoo, these animals are fed, sheltered, and protected from danger. Yet, they lose the thrill of the chase, the tension of survival, and the autonomy of making their own way. Similarly, patients in long-term maintenance programs may be protected from immediate risks but are denied the opportunity to experience the growth and fulfillment that comes with true independence.

The Expansion of Suboxone: Incentives and Consequences

The rise of Suboxone has been fueled by systemic incentives. Pharmaceutical companies like Reckitt Benckiser (now Indivior) crafted a captive market for buprenorphine without the need for conventional marketing. Courts, doctors, and regulatory agencies became gatekeepers, ensuring steady demand for the drug. State programs like Medicaid cover much of the cost, reducing financial accountability for both patients and providers.

As with methadone, Suboxone distribution varies significantly by state. Some states prescribe far higher doses on average, reflecting differences in regulatory control and medical culture rather than patient need. If addiction were purely a medical disease, treatment standards would be consistent across regions. Instead, Suboxone's variability highlights the influence of local market forces and the broader medical-industrial complex.

Despite these efforts, overall opioid use has not declined. In fact, the increased availability of Suboxone coincides with a continued rise in opioid dependency. Patients who enter treatment programs often find themselves cycling between Suboxone, methadone, and other substances

without achieving lasting sobriety. The promise of Suboxone as a solution to the opioid crisis remains unfulfilled.

Toward True Recovery

To break the cycle of dependency, addiction treatment must move beyond harm reduction and prioritize recovery-focused care. Suboxone should be a temporary tool, not a permanent crutch. Treatment programs must emphasize gradual tapering, personal responsibility, and reintegration into society. Patients should be supported in rebuilding their lives through stable employment, strong relationships, and meaningful activities.

Recovery is not a linear process; it requires resilience, setbacks, and ultimately, transformation. Success stories often begin when patients shift their mindset. One notable case was that of a former patient, a corrections officer, who had repeatedly failed programs and struggled with addiction. His situation deteriorated when he became a conduit for heroin in the prison system, jeopardizing his career, integrity, and the safety of inmates. After multiple positive drug tests and ongoing drug use, I had to remove him from the program. He lashed out at me in anger, calling me an “a**hole.”

Months later, he returned, admitting that he wanted to get clean for real. When I reminded him of his outburst, he said:

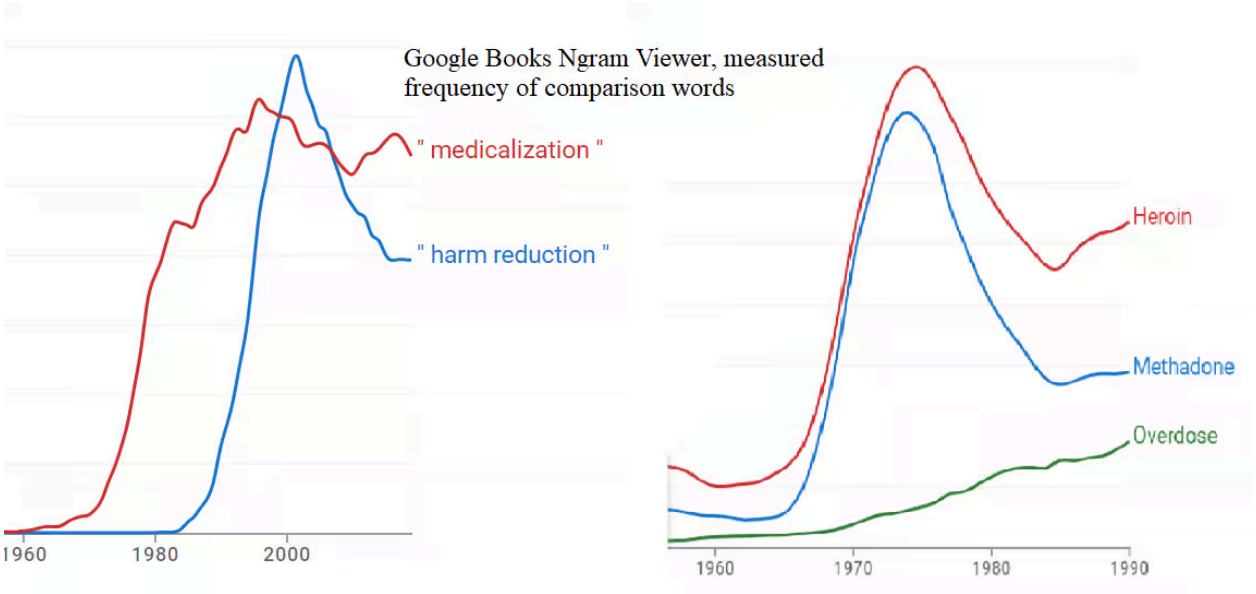
> *"I think I need an a***ole like you to help me get ‘clean,’ for real."*

This time, he succeeded because he was ready to do the work required for true recovery. In contrast, he had found that other providers who were more lenient enabled his destructive behavior, allowing drug use and manipulation of the system.

The rise of Suboxone reflects both progress and pitfalls in the fight against opioid addiction. While it offers important safeguards against overdose, it has also become another form of institutionalized dependency. Patients deserve better than a lifetime of maintenance. They need structured, compassionate pathways to sobriety that restore their independence, health, and dignity. Only by addressing the systemic flaws in Suboxone treatment can we provide real hope for those struggling with addiction.

Appendix 3: The Hazard of Harm Reduction

In the late 20th century, addiction policy underwent a dramatic shift. Terms like “harm reduction” and “medicalization” became central to new strategies aimed at mitigating the dangers of drug use without necessarily achieving full abstinence. This shift paralleled broader social trends, where the idea of reducing immediate risks overshadowed long-term solutions aimed at fostering resilience and personal accountability and coincided with (or caused) rising heroin usage and (ironically) overdoses and opiate deaths.



A Double-Edged Strategy

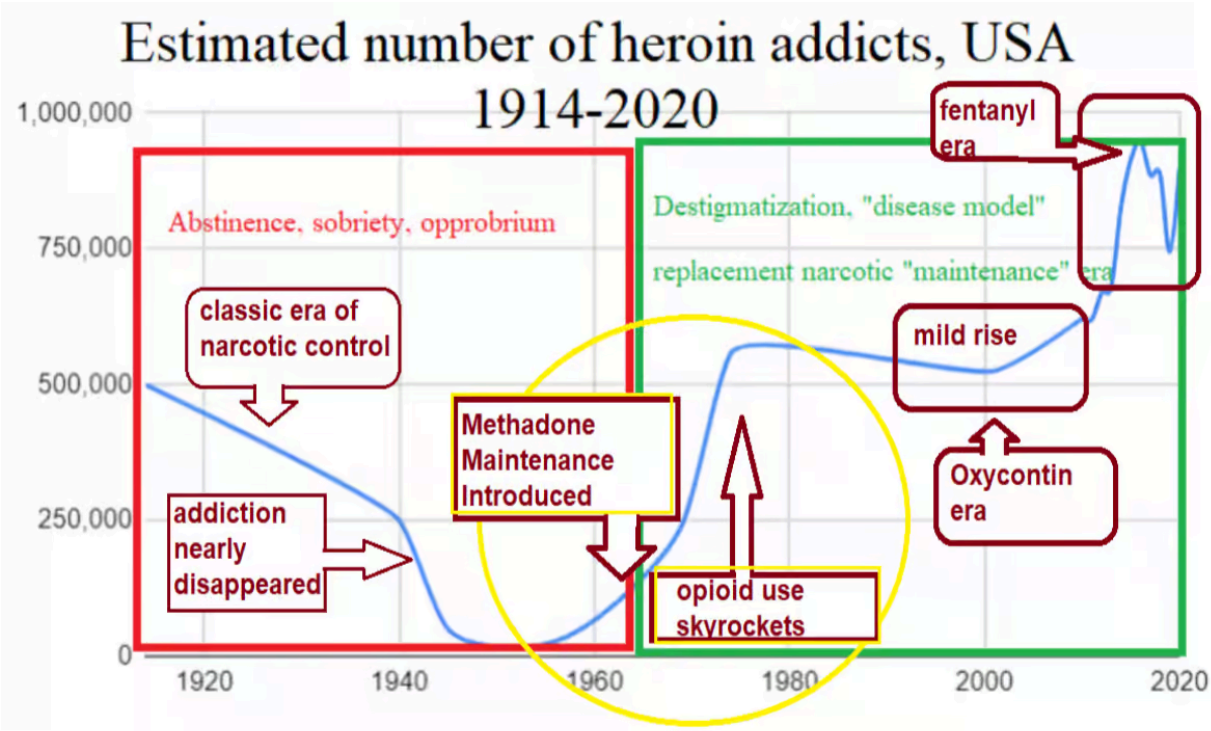
Harm reduction is often presented as a compassionate response to addiction, with initiatives such as needle exchanges, Suboxone maintenance, Police and EMTs’ Narcan kits, six and safe injection sites’ gaining traction. These programs aim to prevent or reverse overdoses, disease transmission, and other immediate harms. However, by removing the natural consequences of risky behaviors, harm reduction policies may inadvertently reinforce those behaviors. This creates what critics call a "moral hazard": a tacit permissiveness that undermines efforts to encourage personal growth and responsibility.

Take, for example, the introduction of condoms in middle schools. While proponents argue that this reduces sexually transmitted infections and unplanned pregnancies, it also implies an expectation that middle school students will inevitably engage in sexual activity. This approach may neglect the potential for students to learn discipline, delayed gratification, and self-regulation—qualities essential for long-term success. Human beings are capable of extraordinary achievements when challenged. They can learn multiple languages, master classical piano, and perform complex dance routines. Lowering expectations by catering to worst-case scenarios risks boxing individuals into limited potential.

As the late Michael Gerson noted, this approach embodies the "soft bigotry of low expectations." Assuming that people are incapable of change not only limits their opportunities but also perpetuates the very behaviors harm reduction seeks to manage.

Historical Context: Medicalization and Moral Hazard

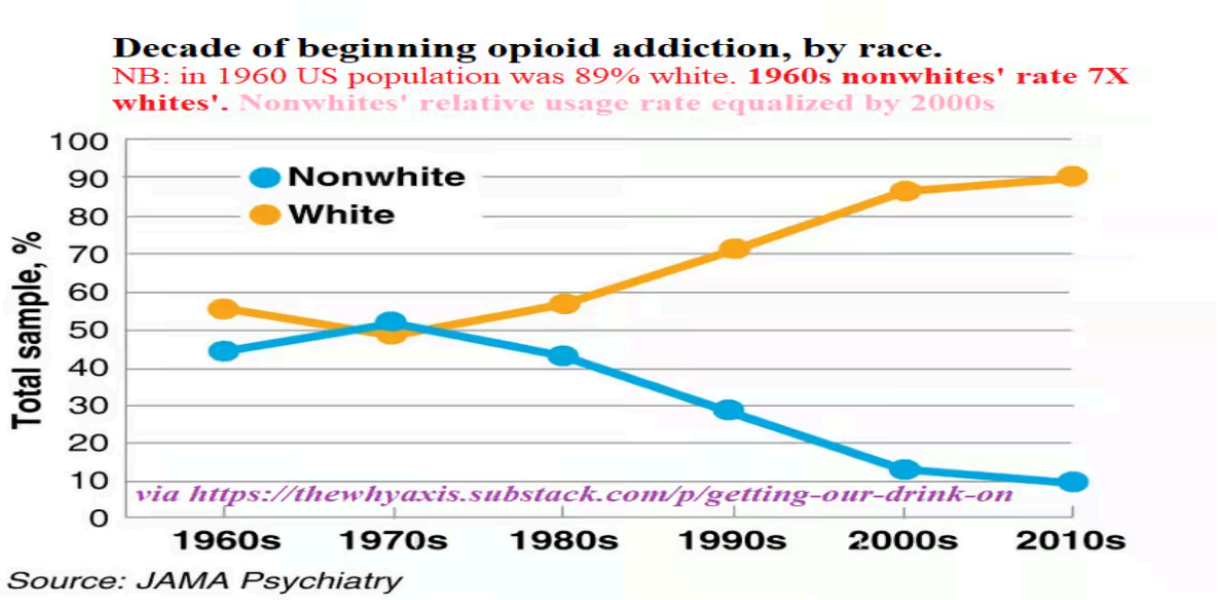
The concept of medicalizing addiction began with methadone maintenance programs in the 1960s. Policymakers framed these programs as solutions to reduce drug-related crime and health crises. By providing legal access to narcotics, they sought to control addiction within a medical framework. However, rather than solving the problem, methadone maintenance institutionalized dependency and created a permanent underclass of patients tethered to state-funded clinics.



Needle exchanges, which gained prominence in the late 1980s during the HIV/AIDS epidemic, represented another facet of harm reduction. While these programs reduced the transmission of blood-borne diseases, they also broadcast a message of acceptance for drug use. The New York City Council's Black and Hispanic Caucus expressed concern in 1988:

> *"It is beyond all human reason and common sense for the city to hand out needles to drug addicts when police and citizens have become casualties in the drug war.""*

These policies were often imposed by distant policymakers who assumed they knew what was best for marginalized communities. Critics argue that such top-down approaches overlook the lived experiences and preferences of those most affected by addiction. By focusing on risk management rather than empowerment, harm reduction strategies risk entrenching the very problems they aim to alleviate.



NB: this graph ^^ gives the false impression of nonwhites' improvement. This apparent divergence is due to a 7X- increase (!) among whites, such that the newer relative percentages ultimately reflect the population distribution, without indicating any actual reduction in usage within the nonwhite population.

The Expanding Market for Addiction

As harm reduction became institutionalized, the market for opioids evolved. Organized crime adapted to the presence of methadone and Suboxone by lowering heroin prices and targeting younger demographics. Government intervention flooded the market with legal narcotics, inadvertently driving demand for street drugs. Studies have shown that as prescription opioids became more accessible, heroin use among adolescents and suburban populations increased dramatically.

For example:

> *"Heroin use is skyrocketing among middle-class, suburban teens. Since 2002, initiations to heroin have increased 80 percent among 12- to 17-year-olds."*[66]

Policies that subsidize or normalize addiction treatment have created captive markets for pharmaceutical companies and clinics. These entities benefit financially from the ongoing treatment of addiction, often without a clear path to recovery for their patients. Unlike bartenders who rely on voluntary customer choice, medical providers administering Suboxone and methadone operate under the protection of state-funded programs. This dynamic raises questions about who truly benefits from medicalized addiction treatment.

Striking a Balance: Accountability and Empowerment

Harm reduction's underlying pragmatism is not without merit. Preventing overdose deaths and disease transmission saves lives in the short term. However, without complementary strategies aimed at fostering independence and accountability, these policies can devolve into enablers of chronic dependency.

[66] https://www.salon.com/2012/08/31/teen_heroin_use_on_the_rise/

Thank You!

Thank you for reading this book. Better yet, thank yourself! By reading it, you've shown that you're interested in withdrawing to freedom. You may even have begun implementing, with your healthcare provider, the first steps of the Bock Method. Keep up the good work!

[Contact info….]