

A POINT OF VIEW CONCERNING TREATMENT APPROACHES WITH NARCOTIC ANTAGONISTS

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When narcotic antagonists were first introduced into the treatment of drug addiction, patients were placed on the medication without regard to selection criteria and assessments of "successes" or "failures" were made only on the basis of their retention in the program. Since that time, however, our evaluation criteria have become more refined and we have begun to look at more complex questions such as: Are these compounds "helpful" and if so, "for whom" and by what treatment techniques can we augment their usefulness? A salient aspect of our nal-trexone studies, for example, is addressed to the question of "for whom?" Hopefully when our data analysis is completed, it will contribute to either affirming or negating the conceptual model that we have formulated to aid us in the differential diagnosis and treatment of opiate dependent individuals.

For my presentation today I have chosen to share with you some aspects of our point of view concerning treatment approaches based on our clinical experience. As investigators, we are all committed to the rigors of science with its demand for carefully controlled data. However, I am not addressing myself to specific research data, but rather to some issues concerning the application of this class of compounds to clinical treatment programs.

Although we are using psychoactive compounds sharing a specific pharmacologic property that can and has been used advantageously -- it would, in our opinion, constitute a serious error for a treatment program designated to evaluate their clinical efficacy to use the same model as that used to evaluate other pharmacologic therapies: compounds, for example, whose purported function is to alter an underlying physiologic malfunction or disease

process and which may relieve, eliminate or worsen a "target symptom." It is easy to discern drug effects when they cause a marked change (positive or negative) on some aspect of the psychopathology being examined -- such as the effect that lithium has on a manic reaction or imiprimine on depressed states. Narcotic antagonists do not directly affect an individual's psychopathology; their benefit is only secondary, by protecting the patient from the effects of self-administered opiates.

Therefore, the model to follow is not analogous to one in which you can explore the degree to which the compound, by itself, affects an identifiable clinical syndrome that, in most instances, is ego dystonic. Few people, for example, derive gratification from depressive symptoms. All addicts get gratification from their drug use, regardless of the consequent "secondary losses" that may be incurred. To pursue the analogy further -- we observe and describe varying degrees of "secondary gain" that patients may derive from their illness and that often lead them to interrupt their treatment regimen. The gain, however, for the individual addicted to drugs is "primary" not secondary. It is the "secondary losses" that bring him to us for treatment. We know with absolute certainty that antagonists prevent relapse to opiate addiction. It is contingent only upon the patient's continuing to take the medication at an adequate dose over a sufficient period of time.

Ah, there's the rub, --- PROVIDED HE TAKES THE MEDICATION. A major thrust of our clinical efforts, therefore, will need to be devoted to bringing to bear all our ingenuity and resourcefulness to help convert the ego functions of our patients so that their attitude toward continued opiate use is changed and it becomes viewed by them as a "primary loss" and not as a gain. In part, it becomes our ability to (and means wherein) we accomplish this task that must be evaluated. Thus the clinical efficacy of these particular compounds becomes inseparably bound to the efficacy of the clinics that use them.

I will discuss some of the clinical techniques we consider most important, although we must emphasize the obvious: Good clinical judgment is never fully explainable solely on the basis of specific techniques.

When working with narcotic antagonists, it is essential that the staff help patients to learn that their treatment is not the medication alone. Obviously, to do this, the staff themselves must know it, understand it and believe it! It takes a helluva lot more input to treat a drug addict than simply dispensing medication. As Dr. Lee Schwartz, a collaborator in our research, often reminds me: "It takes more than a pill to cure an ill."

The medication can, however, be used as a tool for the initial focus of therapy -- it can be a way of enabling the patient to begin to trust the therapist and to establish a therapeutic alliance. Whatever diverse therapeutic techniques are employed, we cannot overemphasize the importance of a good rapport and positive transference between the patient and a therapist. This relationship can be beneficial in many ways -- ranging from providing support the patient needs during the post-withdrawal period to substituting for emotional resources that are lacking in the patient's life. When we first began working with antagonists and did not provide such therapy, our results were poor; they improved when each patient was assigned to a trained and empathic therapist and was seen regularly, even if contacts were only brief.

Gradually, the patient can learn to look to the therapist -- rather than to opiates -- for gratification of dependency needs, relief of anxieties and solutions to the problems and dilemmas of his life. It is through this therapeutic relationship that a patient can get positive reinforcement for making choices that will contribute to his achieving a more stable, socially acceptable lifestyle, while deconditioning (or at-least non-reinforcement of his drug-seeking behavior is taking place.

One aspect of treatment that should be considered is the benefit a patient may derive from

having conditioning theory explained to him, so that he may begin to look for signs of conditioned responses within himself. The value for the patients who have this understanding has been remarkable in some of our follow-up interviews. When conditioning is explained to patients, it has the additional benefit of alerting them to the possibility that they could become readdicted at some time in the future -- even after a long period of successful antagonist treatment.

However, stopping the antagonist and resulting opiate use is, by itself, an insufficient criterion for labeling the treatment a failure. Would you say that digitalis is not clinically efficacious if a patient with congestive heart failure stops taking it? In our studies we have found that the length of time patients take naltrexone increases with each successive readmission.

The model we use should be similar to the one we use in treating chronic medical illnesses. A patient must be told that whenever medication is discontinued, he can and should ask to be put back on the antagonist whenever he feels tempted, or has begun, to use opiate drugs again. Imagine the positive affect it has on patients and their families when they can view addiction as no worse than other recurrent medical problems for which treatment is available. The emotional impact on the patient is usually profound, since he has previously experienced negative attitudes and rejection -- if only by being labeled a "failure" -- whenever he has become readdicted. When the treatment staff is non-judgmental about his opiate use, it just "blows their minds." We've seen this happen over and over again -- "You mean, Doc, if I goof up, I really can come back to the program???"

The focus of treatment needs to become for patients to change their "lifestyles," rather than to "never use drugs again." If this is the correct focus, as we believe it should be, then it follows that the treatment staff must believe it, in order to convey it to the patients. For certain individuals, a meaningful commitment

to rehabilitation with an antagonist can only be made after relapsing and becoming readdicted one or more times. For some it entails getting disgusted with themselves, others need to know their therapist long enough to trust that the therapist cares about him and his needs and will reach out to help him through times of stress.

We have found that the most successfully rehabilitated patients are those who learn to rely more and more on the therapist for help, especially during the early phase of treatment. As this relationship begins to become a trusted and consistent source of satisfaction, these patients dwell less and less on the instant gratification afforded by opiates.

Here, a specific case example may best illustrate this point:

A 28-year-old man who had been on methadone maintenance in our program for four years, felt "ready" to be drug free, having made significant changes in his life while on methadone. His therapist concurred, but suggested naltrexone as a transitional treatment. He initially refused, stating that he felt he didn't need it. For two months following the last methadone dose, he struggled against growing temptation to use opiates to relieve his secondary abstinence symptoms and severe depression, which seemed to get worse instead of better as time went by. He had 400 mg methadone at home and became obsessed by the thought of the instant relief it would offer. During this period he saw his therapist daily and called her frequently at night or on weekends, when he was under stress or having severe symptoms. Finally his symptoms became so severe he knew he could no longer resist the temptation to use dope again without more help. He phoned the clinic and was told to come right in, which he did. Riding through East Harlem -- where he used to take drugs -- on his way to the clinic he experienced severe withdrawal (conditioned abstinence) and was tempted to get out and cop some dope. He arrived at the clinic and said he felt it was necessary to try the original suggestion that he take naltrexone.

On follow-up, he stated that he knew the naltrexone would give him "peace

of mind," since he would be protected against losing control and impulsively using drugs. He added, however, that without the on-going relationship with his therapist, he would have given in to his urge to use dope and if he did so even once, he would have become readdicted, felt himself to have failed, and perhaps never tried to detoxify again. He said his experience led him to feel that in the initial opiate-free months, it was his therapist that helped first, then it was the naltrexone, but without both of these factors. he couldn't have achieved his goal. He took naltrexone for one month only, then stopped when he felt ready. Today, more than two years later, this patient continues to be opiate free. We have had many patients express the same theme: The antagonist and the therapist must work together to help them.

Clinic attendance is also a crucial issue. Methadone patients come because they fear getting sick: antagonist patients don't have that worry. Their attendance must be based on a strong desire to remain drug-free, fear of family or other external pressure, or a good relationship with their therapist. Few patients can be expected to come to the clinic because of a commitment to their therapist initially. It becomes a very strong message to the patient, however, if he skips one day of medication and is called by his therapist to find out where he is. Our patients often express surprise and state that they have never been "cared about in this way" by other treatment programs. A few such calls, and soon many patients begin to respond to that caring with a commitment to their therapist that includes coming to pick up their medication.

Requiring daily medication is usually a good idea with antagonist patients, at least in the initial months of treatment. It not only provides some structure to their lives and puts them in frequent contact with the staff, but also can serve to alert the staff to the potential for readdiction whenever a patient skips a day of medication. Many patients feel they can skip medication and use opiates "once in a while." We have found that antagonists become useful in respect to this issue for

two reasons. Since the patient must make a conscious decision to skip medication, he cannot deny responsibility for his impulsive drug use. Many good antagonist candidates -- those who we believe have the best prognosis -- are also those whose drug use is impulsive.

By helping the patient understand these dynamics, the therapist forces the patient to become aware of his choices, instead of believing that he used drugs because he was-"weak-minded" and implying it was beyond his control. We often tell patients and their families that refusal to take medication is analogous to stating an intention to get "high." A patient who is ambivalent about taking medication on a particular day is less likely to act on his impulse to skip it, if he knows that doing so is equivalent to announcing to his family and the staff: "Today I plan to shoot heroin." We have found that involving the family in this way places the patient in a situation where he can rely on external pressures to help him through times of ambivalence, until he can integrate his desire to remain drug free on a new emotional level, under more conscious control.

In conclusion we strongly urge that you treat your study subjects as patients -- exercising the same degree of concern, interest, sincerity and dedication to relieve human suffering and to restore health as you would do for any other sick person.

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