A Holistic Methadone-Assisted Treatment Program: Positive Outcomes for Patients and Their Families

A Research Paper

Presented to

The Faculty of the Adler Graduate School

In Partial Fulfillment of the Requirements for

the Degree of Masters of Arts in

Adlerian Counseling and Psychotherapy

Kathy Newton

January 2008
Abstract

Physiological and psychological implications are part of the controversy surrounding methadone assisted treatment programs. Some have questioned whether a methadone assisted treatment program replaces one problem for another for the addict. This thesis paper explores the positive aspects of methadone assisted treatment programs and how a heroin/opiate addict can successfully adapt to life as a recovering addict, even after multiple attempts to stay clean and sober.
A HOLISTIC METHADONE-ASSISTED TREATMENT
PROGRAM: PROMOTING POSITIVE OUTCOMES FOR
PATIENTS AND THEIR FAMILIES

Outline

Introduction

History of the Methadone-Assisted Treatment Program

Purposes of Orientation and Encouragement

Methodology

Measures and Definitions

Addiction

Patient and Family Support

Lifestyle Change

Procedure

Part 1- Methadone Counselor’s basic functions

Part 2- Harm Reduction vs. Treatment model

Literature Review

An Analysis and Interpretation of Methadone-Assisted Treatment Programs

Physiological

Cognitions

Psychological

Emotions (unstable and erratic mood)
Motivation for Change

Social Interest

Acceptance

Sense of belonging

Life tasks (love, social, work)

Sense of Purpose

Goal

Mistaken belief

Significance and meaning

Skill Competency

Self-confidence

Coping skills

Vehicle for Change

Counselor’s core functions

Case studies

Investigation of Methadone-Assisted Programs and the Intersection with Adlerian Psychology

References
Introduction

History of the Methadone Assisted Treatment Program

Methadone therapy is used to aid in the detoxification and maintenance of patients who are dependent on opiates, particularly heroin, and the treatment of patients with chronic, severe pain. Methadone maintenance offers an alternative life style that aids the patient in abstaining from heroin or opiates in order to live life productively. “Methadone therapy achieves this by preventing opiate withdrawal symptoms, blocking the euphoric effects of heroin, and minimizing the craving of heroin” (Anderson & Kearney, 2000). Methadone, a synthetic narcotic, has been used for more than 30 years to treat opioid addiction. Methadone programs providing counseling as part of the treatment plan are likely to have a more favorable patient outcome in relation to positive cognitive and behavioral changes during treatment. Patients in the minimum treatment program showed a decrease only in their use of opiates.

Methadone side effects include restlessness, sleep difficulties, weakness, dry mouth and decreased sex drive and can vary from patient to patient. A patient should talk to his or her doctor before using pain medications, sedatives, tranquilizers, muscle relaxers, or other medicines that can make one sleepy or can slow breathing. During the intake process, a patient must see an on-site physician in order to regulate the methadone dosage.

Purposes of orientation and encouragement

National Institutes of Health (1997) found the following:

A 1997 National Institutes of Health (NIH) report estimated the financial costs of untreated opiate addiction at $20 billion per year. These costs, combined with the social costs of destroyed families, destabilized communities, increased crime, increased disease transmission, and increased health care costs, mean that opiate addiction is a major
problem for affected individuals and society (Centers for Disease Control and Prevention, p.1). Methadone reduces the cravings linked with heroin use and impedes the high from heroin, but it does not provide the high-spirited surge. Even though the patient is physically dependent on opioids while on methadone treatment, the patient is freed from “the uncontrolled, compulsive, and disruptive behavior seen in heroin addicts” (ONDCP, p.1).

Methadone maintenance treatment (MMT) is based on the individual needs of each patient and withdrawal can be a slow process for most. Many MMT patients require continuous treatment, sometimes over a period of years. Because of the slow process, it is possible to maintain an addict on methadone without adverse side effects.

According to the Office of National Drug Control Policy:

Methadone maintenance treatment provides the heroin addict with individualized health care and medically prescribed methadone to relieve withdrawal symptoms, reduces the opiate cravings, and brings about a biochemical balance in the body. Important elements in heroin treatment include comprehensive social and rehabilitation services (p.1).

There are many benefits to methadone maintenance treatment and these benefits include: a reduction or stoppage of injection drugs, reduction of the risk of overdose and sexually transmitted diseases, reduced mortality, reduction of criminal activity, improved family stability and employment potential, and possibly improved pregnancy outcomes. MMT is extremely cost-effective.

On the other hand, some view MMT as merely a trade of one addiction for another. A recent study claims, “MMT has sometimes been met with limited acceptance by communities, health care providers, and the public” (IDU/HIV prevention p.2). There is cause for concern in
the expansion of MMT programs because of the possibility that it may draw crime and drug dealing; some fear the addict may sell methadone to supplement their income or may use it to aid their friends with their own withdrawal. MMT programs are strictly controlled and regulated to prevent misuse of the narcotic. Subsequently, these regulations and program controls can hinder the flexibility that may be a key component to the optimal length of treatment and dosage for the addict. “The regulations also have limited the number of physicians who are available to treat heroin addiction and the settings and locations in which treatment can occur” (IDU/HIV prevention p.2).

The United States Department of Health and Human Services (DHHS) adopted a new system for the regulation and monitoring of MMT in 2001. The directorship for MMT shifted from the FDA to the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. The new system relies on accreditation of MMT programs in the United States that are operated by independent organizations in cooperation with treatment standards that have been developed by CSAT. “MMT can help injection drug users (IDUs) reduce or stop injecting and return to productive lives” (IDU/HIV prevention p.1).

Contingency management therapy and cognitive-behavioral therapy can be beneficial to a heroin addict, when applied with pharmacotherapy. “Contingency management therapy uses a voucher-based system, where patients earn ‘points’ based on negative drug tests, which they can exchange for items that encourage healthy living” (NIDA, p.3). Cognitive-behavioral therapy intercedes in a way that will shake the patient’s awareness of the negative outcome the drug could have and to help the patient live with the struggles of life and how one can cope in a more positive way.
Methodology

Measures and Definitions

Addictions

Addictions can appear in many forms and vary from person to person. For the purpose of this paper, the focus will be on heroin, prescription drug, and alcohol addiction. Some develop addictions to certain foods or beverages. Some people develop addictions to possessions, occupations, money, and relationships, among other things. “Many people assume that addiction is simply an overdose of drugs and that the addict is just a drug user who chooses to use too much” (Science: Differences, p.1). The study goes on to say, “research has shown that addiction, unlike casual drug use, is no longer a matter of free choice.” Alan Leshner, Ph.D., (NIDA) says, “Functionally you’ve moved into a different state, a state of compulsive drug use. People have a lot of trouble understanding that addiction is not an issue of choice or will or morality.”

Addictions can be cunning and baffling. The addicted person can be overwhelmed with a powerful compulsion that many times leads to a binge. Even though an addict may look the same as others on the outside, it is what’s going on inside of the addict’s brain that accounts for the difference.

A scenario depicting the patterns of a prescription painkiller addict could appear as follows: The addict strains a muscle while doing a morning workout at the gym. The physician prescribes pain medication for the strained muscle because the pain is unbearable and the painkiller will help to manage your pain. Yet months later, long after the initial injury, the addict is still taking the initial painkiller that was prescribed. The pain is becoming more frequent and it is hard to manage the pain so the addict doubles the dose. Before he or she realizes it, the initial dose of medication is not having the same effect.
Waismann (2002) found the following:

Today, approximately 75% of our patients suffer from a dependency to painkillers like Oxycontin. We recognize that all patients who are physically dependent on prescription painkillers, as well as other opiates, become dependent through no fault of their own. Their disease is a chemical imbalance that requires expert medical treatment in a safe, humane and effective environment (Waismann Method, p.1).

**Patient and Family Support**

For some addicts, family support can be difficult for a wide variety of reasons. Family members might have a serious drug abuse problem themselves; emotional, sexual, or verbal abuse may have occurred between the patient and family at some point; or there may have been other serious problems in family relationships that make it hard for the family to support the addict.

While in the methadone maintenance program, it is up to the patient and case manager (or counselor) to seek support from other people in the patient’s life who are concerned about the patient’s best interests and well being. There may be extended family, neighbors, community, church groups, a teacher, a coach, or an outreach worker who can be of help to the patient if the family is not willing or able to offer support. When it is possible, while talking with the family it is helpful to address the addiction as “the problem” rather than the patient as “the problem” and to focus attention on how the person’s addictions impact everyone in the family. It is imperative to listen to all family members but not to forget about the methadone patient’s needs. It is important to acknowledge and validate the families’ efforts to find a solution and the difficulties they have come up against in the process. It is helpful to engage in reflective listening while talking through any feelings of anger, guilt, fear, frustration, and distrust. Any handouts on
supportive self-help may be useful for the family. Most of all, the entire family (including the patient) will need lots of encouragement along the way. The entire process may take some time and over-night results should not be expected.

*Lifestyle Change*

The first area the addict will have to address will be the withdrawal symptoms from the drug he or she is trying to eliminate. It is crucial to the patient’s success during the withdrawal stage that the patient follows the recommendations of the methadone assisted program. It is also critical that the patient be closely monitored in the initial stage so that the correct dose is being administered.

Lifestyle change can offer many benefits to a successful heroin addict who has addressed their drug addiction while attending a methadone assisted treatment program. Some of the positive alternative life style changes that can happen include moving from unemployed to employed; from being homeless to obtaining housing; from criminal activity to living in a trustworthy manner; having personal hygiene that is undesirable to washing daily; having no means to wash clothes on a regular basis to having access to launder clothes when needed; from having no support to obtaining supportive people being in the soup line to serving soup to others. These lifestyle changes may seem unimportant to some, but to a heroin addict, they can embody the best that has ever happened to them. The ultimate goal of a methadone assisted treatment program is to develop strategies to promote a drug-free lifestyle for the addict while on the prescribed doses of methadone. The client can then lead a life that has meaning and significance while remaining clean from the usual drug of choice.
Procedure

Part 1- Counselor’s basic function

The following list of counselor core functions was developed from the list of “Twelve Core Functions and Global Criteria” initially developed by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). The counselor core functions are from Colonial Management Group, L.P. (2005).

1) Screening: the process by which a patient is determined eligible for admission to a particular program.

2) Intake: the administrative and initial assessment procedures for admission to a program.

3) Orientation: describing to the patient the following: general nature and goals of the program, rules governing patient conduct and infractions that can lead to disciplinary action or discharge from the program (residential programs), the hours service is available, treatment costs to be borne by the patient, if any, and patient rights.

4) Assessment: the procedures by which a counselor/case manager or program identifies and evaluates an individual’s strengths, needs, abilities, and preferences for the development of a treatment plan.

5) Treatment planning: the process by which the counselor/case manager and the patient identify and rank problems needing resolution, establish agreed upon immediate and long term goals, and decide upon a treatment process and the resources to be utilized.

6) Counseling: the utilization of special skills to assist patients, family members and /or significant others to achieve treatment goals and objectives through exploration of a problem and its ramification, examination of attitudes and feelings, consideration of alternative solutions, and decision making.
7) Case management: those activities that bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts.

8) Crisis intervention: those services that respond to an alcohol and/or drug abuser’s needs during acute emotional and/or physical distress.

9) Client education: provision of information to individuals and groups concerning alcohol and other drug abuse and the available services and resources.

10) Referral: identifying the needs of the patient that cannot be met by the counselor/case manager/program and assisting the client to utilize available support systems and community programs.

11) Report and record keeping: charting the results of the assessments and treatment plan, writing patient-related reports, preparing progress notes, discharge summaries and other client-related data.

12) Consultation: communicating with other staff and/or outside professionals to assure comprehensive, quality care for the patient.

Part 2- Harm Reduction vs. Treatment Model

The concept of harm reduction is not new and is evident throughout our daily lives. Some examples of harm reduction include seatbelts in cars, filters in cigarettes, and fences around swimming pools. A methadone assisted program could be beneficial to a person desiring to live a drug-free life. A pharmacological treatment program such as a methadone assisted program can aid the patient in positive outcomes such as avoiding relapse, and providing a period of timeout from the drug of choice. During such a program, the patient can learn positive and useful skills that will assist him or her to achieve long-term changes. Therefore, the methadone-assisted
program could be defined as a harm reduction model that could be beneficial to someone who has abused heroin and/or abusing opioids.

The pharmacotherapy protocol for a methadone treatment patient is prescribed by a medical practitioner who is part of the methadone-assisted program. A methadone assisted treatment program is strictly enforced by Federal Government guidelines. It is a program designed with patient involvement on a regular basis for “optimal” patient outcome. The treatment facilities and counselors work hand-in-hand to encourage, educate, support, and work closely with each patient to provide optimal results. The doses are closely monitored and if a patient has missed an appointment, the counselor calls and verbally notifies the patient that consistency is critical to a positive outcome and that the program is designed for “daily” doses of methadone prescribed specifically for each patient. If there are an adequate number of volunteers, some methadone treatment clinics offer a weekly support group for participants in the program.

The treatment model described in this paper is the 12-step concepts of Alcoholics Anonymous (AA), which emphasizes abstinence from alcohol. As the Alcoholics Anonymous Book (1976) says, “Our [AA members’] stories disclose in a general way what we used to be like, what happened, and what we are like now. If you have decided you want what we have and are willing to go to any length to get it—then you are ready to take certain steps” (p.58). An AA group typically consists of members who are trying to abstain from using alcohol. AA is a program that is typically voluntary (although it can be court-ordered) and suggests that the person attends meetings on a regular basis to aid them in maintaining an alcohol-free life-style. AA strongly suggests that a member get an AA sponsor so the sponsor can help the new member
with individual issues. The ultimate goal of a member is to live in a “sober state” on a 24-hour basis. “Living one day at a time” is a slogan used in AA.

AA is about making a commitment to a drug-free lifestyle and it requires an attitude of coming to the acceptance of one’s powerlessness over drinking or drug use. This is a foundational first step to the road to living an abstinence lifestyle. An AA member also develops relationships with other members in the group and perhaps can find a common bond with the others in his or her AA group thus creating a support system to help them to live sober one day at a time. Alcoholics Anonymous is built on the philosophy of the Twelve Steps and Twelve Traditions. Ideally, anonymity is adhered to by all in AA and can be valuable to all members.

Some professionals may suggest individual counseling or therapy to the person in AA. The “harm reduction” model and Alcoholics Anonymous program are based on the “same end result” and that is to live a life without a drug altering component that inhibits one’s ability to contribute to society and to live a life worth living.

Literature Review

An Analysis and Interpretation of Methadone-Assisted Treatment

Methadone maintenance is a program for heroin addiction. “Methadone is a rigorously well-tested medication that is safe and efficacious for the treatment of narcotic withdrawal and dependence” (ONDCP, p.1). This synthetic drug has been around for over 30 years and has been used to treat opioid addiction.

According to the Office of National Drug Control Policy:

Heroin releases an excess of dopamine in the body and causes users to need an opiate continuously occupying the opioid receptor in the brain. Methadone occupies this
receptor and is the stabilizing factor that permits addicts on methadone to change their behavior and to discontinue heroin use (p.1).

Furthermore, because withdrawal from methadone is slower than that of heroin, it is possible to maintain an addict on methadone without severe side effects. In some cases, patients require continuous and longer term treatment than others.

*Physiological*

*Cognitions.* After 2 months of treatment the cognitive function of methadone maintenance (MM) patients was improved according to an empirical study. “More recently, Ornstein, Iddon, Baldacchino, Sahakian, London, & Everitt (2000) found that chronic heroin use impairs performance on sequence generation tasks, spatial working memory, and visual pattern recognition memory. These findings are in contrast to early reports suggesting that opiate users and controls do not differ in frontal lobe function (i.e. abstract thinking; Bruhn & Maage, 1975) and verbal fluency” (Rounsaville, Jones, Novelty, & Kleber, 1982).

There is, however, a growing body of evidence that suggests that chronic opiate use is associated with significant impairment in several dimensions of cognitive functioning. The subjects included seventeen opiate-dependent people who were enrolled in an MM program in Boston, Massachusetts. The ages of the subjects ranged from 25.8 to 60.1 years and consisted of 11 men and 6 women. All participants willingly signed an informed consent form prior to the study and every morning each participant received a daily dose of methadone. Urine samples were collected for drug screening and a breath alcohol test was administered daily upon arrival to the hospital. Subjects testing positive for pregnancy or alcohol were not permitted to partake in the study. A trained research assistant administered the Addiction Severity Index (ASI) to evaluate any problematic areas in participant’s life or drug use, alcohol use, and illegal activity.
The next step was a neuropsychological assessment of the participants (Gruber, Tzilos, Silvers, 2006).

Some earlier findings (Appel & Gordon, 1976) reported that “the performance of methadone maintenance patients does not significantly differ from that of former heroin abusers or normal controls.” However, a more recent study, (Mintzer & Stitzer, 2002) reported that “patients in methadone maintenance of 45 months or longer displayed the same time measurement resemblance and idea modifications as the tested patients. These findings imply some parts of neurocognitive functioning (attention) may be unaffected by long term methadone maintenance treatment, on the other hand, learning and memory may be more liable to methadone use.”

Psychological

Emotions (unstable and erratic mood). Emotions and the relation between sex trading and psychological distress was studied in face to face interviews with women identified at a methadone maintenance clinic in New York City. The study involved 280 women and it revealed that 32% had traded sex for money or drugs in the previous year. Compared to the other participants in the past year, these women reported less education and higher rates of imprisonment and were also using crack/cocaine and alcohol. The findings of this study stress the need to consider the interrelation of psychological distress, abuse, and addiction in designing public health interventions addressing methadone maintenance women.

The phenomenon of addiction can affect other areas of the addict’s life. In the recovery process, an addict may have to look at other parts of his or her life such as relationships, occupation, spirituality, intimacy, leisure time, parenting, budgeting, communication, and accountability. An addict may need additional therapy in these areas. A new way of living can
emerge when the addict is clean and sober. The addict may need extensive therapy, depending on his or her life circumstances. Some of the skills may have been present at some point in life but the addiction had taken over and the heroin or other drug became paramount. Thereafter, it is not only about the addiction.

Some addicts may benefit from a group setting that targets certain areas with which they are struggling. The group may help them to open up about certain areas that others have openly discussed and shared. Sometimes a group can offer a place where trust issues can be developed. Lastly, there can be a common bond that develops within the group because members have gone through similar situations.

Counseling can be effective because it can help the addict see some patterns of behavior and how the patterns are holding them back from living life to the fullest. “Adler asserts that what we were born with is not as important as what we choose to do with the abilities and limitations we possess. Adlerians put the focus on reeducating individuals and reshaping society” (Corey, 2005). All behavior is purposeful and also goal-orientated. The reasoning of Adlerians is that personality can be better understood in a holistic and systemic fashion.

Motivation for Change

*Social Interest*

*Acceptance.* Acceptance is part of life and if one is head strong “against accepting” something in life, it can reap havoc. Part of the process of a methadone assisted program is the “role” of the client’s assigned counselor. The client and counselor work together as a team throughout the program. It is important to build the client/counselor relationship in a trusting fashion. A client may be more resistant to the program if he or she is not accepting of current circumstances. Ultimately, the clients come to the program of their own free will. The
counselor’s role is to explore, promote, strategize, educate, and advocate for the client and to keep record of the client’s dosage of methadone during the drug withdrawal process. All of this can be done “only” if the client is accepting of the program.

*Sense of belonging.* The sense of belonging is essential to “all” humans (Ansbacher & Ansbacher, 1956). As part of being human, there is a sense of significance and meaning in life. For some addicts, the sense of belonging has been severed due to cognitive distortion. Some can start to feel that the addiction has taken over many areas in their life. Somehow the addicted person needs more of the drug more frequently to get a higher high because the last drug episode was not equal to the previous. The addict may feel that they only belong to the drug and nothing else. For some, the addiction gravely affects other areas that are necessary to maintain life functioning such as housing, food, transportation, recreation, employment, family, social status, and survival.

*Life tasks (love, social, work)*

All three of the life tasks are necessary to uphold social interest throughout life. First, the occupation (*work*) life task “may be regarded as representing all claims of the human community” (Dreikurs, 1989). For many, one’s work is an important part of life, and one can devote a sizable portion of time into work. Working is essential in making a wage so one can pay for the necessities of life. As a result, many hours, days, and years are committed to an occupation. If clients are trying to get back into the work force, it may be helpful to educate them regarding appropriate social skills that they may be lacking as a result of drug use. Perhaps they need assistance with cognitive restructuring, or help with organizing and planning before entering the work force. Professionals, working along side the client and reinforcing the positives and successes, can empower the recovering addict.
Secondly, the social task is necessary to be social with others in order to satisfy an everyday need. Sadly, all too often, an addict who is dependent relies on the “drug” as their social support. This dependence has grabbed hold of them, mind, body, and soul, in such a way that was certainly not planned beforehand. “The way in which he fulfills the task of friendship [social] is the best measure of the strength of his social interest” (Dreikurs, 1989).

Finally, is the love task “demands a maximum of social interest, because it involves the closest of all contacts between two human beings” (Dreikurs, 1989). The love task can be interrupted by an addiction that is causing many difficulties in a client participating in methadone assisted program. Perhaps love of self has diminished as a result of drug abuse. Some may experience the inability to love another because of barriers such as the lack of trust, respect, reliance, security, and general interest. Again, in working with clients in the MMT program, it is our duty to instill an internal locus of control, to learn and practice self-efficacy skills and to help them define themselves as more than their addictions or symptoms.

Sense of Purpose

Goals. Goals can give a client a sense of direction and purpose and can give them “things” to work towards. “The dynamic value of mental, emotional, and attitudinal movements consist of their direction toward, or determination by, a goal which has for the individual the meaning of securing for him what he regards as his position in life” (Ansbacher & Ansbacher, 1956). Purpose and position are an important factor in one’s life and a goal can aid in achieving a sense of purpose. As a professional involved in the client’s methadone-assisted program, one can participate in the goal-setting and promote positive outcomes that the client may not be able to see or understand due to the addiction.
Mistaken beliefs. Mistaken beliefs are part of one’s past and can be embedded in the cognitive beliefs. The idea is to identify the basic core mistaken beliefs. Next, to identify the fictive goal and the behaviors used to attain it; this is a collaborative process between counselor and client. This will take some time to identify and to change and may require some outside therapy from a qualified therapist (possibly one who practices the Adlerian theory).

Significance and meaning. Significance and meaning are part of one’s life. Sometimes, through no fault or intention of the individual, a traumatic life experience (such as addiction) can cause the individual to think about or question one’s significance and meaning in life. As a part of the MMT program, a counselor can encourage and implement awareness of hopefulness around the client’s life while working together.

Skill Competency

Self confidence. The addict’s self confidence may have been significantly altered due to many different causes throughout his or her life and as a result of drug use. It may be a good idea for the counselor to reinforce and help the client to build-up his or her self confidence; depending on the level of self confidence, it could be a slow process and will take some time to rebuild.

Coping skills. Learning different coping skills may be a slow process for the client, depending upon the duration of the addiction. It may be a good idea to connect information and skills with personal goals. The client may have to develop a safety or crisis plan. Examples of a crisis plan would be to address such questions and the signs that he or she is in crisis and to document them as they are reported to you. Next, ask what helps calm them down when they are in crisis. Then, suggest that they have emergency contact phone numbers available. Discussion of coping strategies with the client is beneficial as it can help them recognize the symptoms that
may lead to a crisis. To aid in client awareness, the counselor will implement a curriculum of a possible symptoms that can lead to a crisis. The counselor will assist with the organization and planning of crisis plan. The counselor will encourage healthy choices and promote hope and positive expectations that will lead to positive outcomes.
Vehicle for Change

Counselor core functions

A counselor’s utmost responsibility is to “do no harm” and work collaboratively with the client’s long term goals in promoting positive outcomes for the patient and their family while the patient attends a methadone assisted program. Short term goals need to be addressed first; it may be as simple as staying in the program despite the hassles it may provide in the beginning. Long term and short term goals are equally important to the client’s success in the program. It isn’t until the addict and counselor finds out these goals that progress can occur. The counselor can build on the client’s strengths and provide any resources necessary for success in the program; and most importantly to encourage the client. They can’t just live in a vacuum all their lives, although the addiction may have enticed them into doing so.

Case study

This case study is about a 30 year old male named Charles. Charles started drinking as a teenager, smoked cigarettes, and occasionally marijuana. He has three siblings, two sisters and one brother who are younger. His brother Steven is chemically dependent. While he was home, he had started to experiment with some of his father’s prescription medication for back pain. Charles graduated from high school and went to college but dropped out after a year and a half. By this time, he was heavily into cocaine and methamphetamines. He attempted to get a job, but no one would hire him because of his absenteeism. Most of the time, he followed the crowd. He liked to work on cars but could not hold onto a job.

By now he was shooting up heroin. At this period of time, he was not employable and lost his place of residence. His girlfriend gave up on him and left him. He was involved in some
illegal doings to try to support his drug habit but to no avail because he was jailed for drug possession. Charles had to serve eighteen months for a felony charge.

Charles made several unsuccessful attempts at treatment but finally enrolled at the treatment center in Waverly, Minnesota; it took a couple of attempts but he was successful the last time. He tried N.A. off and on but eventually relapsed to heroin. At the tender age of thirty years old, Charles received a referral from his medical doctor to a methadone assisted treatment program. When he entered the MMT program, he was still using heroin and had a job he did not like. At this time of his life he had no relationship with his family because they disowned him. However, he was involved in a couple of short-term relationships with women who were also struggling with their own drug addictions.

The program helped Charles with his heroin withdrawal symptoms, which helped his addictive cravings. After some time, he gave up his cannabis use. His desire, willingness to change, coupled with the methadone assisted program was a positive combination. He still smoked cigarettes, but as time progressed, he maintained regular dosing of methadone, and he went off heroin entirely.

As time went by Charles got hired at a construction company. By now he was off most drugs and was making a paycheck and had his own apartment. He gradually started to date, again; he had met a woman through a friend in recovery while he was in recovery.

He was learning a trade while he attended the MMT program, and he started to save money. In the mean time, his father had attained and maintained sobriety and eventually, they began to mutually repair their relationship. Eighteen months have passed since he started the program. He is now self-employed. He is making connections with his family and gradually building past broken relationships. Charles married and bought a home. He and his wife Carol
have been married for five years and have a home and drywall business on Lake Minnetonka. Charles also has connections with various home builders and is not at a loss for work. As a result of attending the MMT program, Charles is drug-free; he is part of the family again and is doing well. Charles is giving back to the community and has reported that he is happier than he can remember.

Another model of a person who may be part of a methadone assisted program is depicted in the following case study. Ted is fifty years old, a widower, on early retirement from his job, and he recently fell on the ice while taking the garbage out. As a result of the fall, he is dependant on his adult daughter to help him with some household chores. After going to the doctor because of his back injury as a result of slipping on the ice, the doctor prescribed a painkiller. As Ted’s medication became less impactful he returned to the doctor to be rechecked and asked for more pain medication, but the doctor declined. Ted did some internet research while at home and thought he would see if he would be a candidate for a methadone assisted program to help ease some opioid addiction. His doctor agreed with Ted.

After the initial visit with the program physician, the counselor recommended that Ted start the program at the correct dose to help him with back pain and opioid cravings. After a period of nine months, Ted was beginning to gradually withdraw from the prescribed dose of methadone. At the end of Ted’s treatment at the Methadone Clinic, the counselor suggested some alternative ways to help him; acupuncture and massage healing. Ted used a different approach—a more short term approach to his opioid addiction. Nonetheless, Ted (drug-free) is a product of the MMT program that assists “all” based on his or her individualized needs.
Investigation of Methadone-Assisted Programs and the Intersection with Adlerian Psychology

Intersecting Adlerian psychology with the Adlerian concept of “social interest” and a methadone assisted program is worth noting because humans are socially embedded (Dreikurs, 1989). We are relationally connected to others in one fashion or another. One who lacks “social interest” may tend to turn to experimenting with illicit drugs for various reasons. As humans, one can encounter many challenges in life and for some, life can be unbearable, unmanageable, unforgiving, and may lead to using alternate ways to dealing with life’s issues. Some may even withdraw from others and stay isolated. Many lack social skills, due to a wide variety of reasons, and may tend to give up on life.

Methadone assisted programs can encourage a client to try a positive alternative solutions to heroin or opiate addiction. The program can offer support and the needed resources that promote the addicted client to a drug-free life-style. The program counselor will focus on the clients’ strengths and suggest different coping skills that will help them build a life worth living. The program can support the client who is discouraged or dissatisfied. Discouragement can promote one to quit or to take a time out.

The “three tasks of life” is another Adlerian concept (Dreikurs, 1989). First, is the intimacy/love task, the second is the friendship/social task, and finally the occupation/work task. All three of the “tasks of life” have, in some way or another, been altered or eliminated from the addict’s current life-style.
Conclusion

The Holistic Methadone-Assisted Treatment Program: Promoting Positive Outcomes for Patients and their Families is unique in that the client can give back to the community. Methadone-assisted treatment can give a family that has been torn apart due to heroin addiction, a sense of hope in addition to mending broken relationships that were once hopeless. The Methadone-assisted treatment program is a harm reduction model that promotes a heroin/opiate addict to live life on the useful side in order to result in positive outcomes for the entire family.
References


