

Unlinking Feelings from Medication Use in Buprenorphine Patients

One of the most common things that I see in my chemical dependence patients is their persistence, even in recovery, in constantly monitoring and then self-treating their feelings with prescribed buprenorphine (Subutex/Suboxone). The most common feelings are anxiety and anger.

The Problem:

Addicts are constantly modifying how they feel by taking drugs. This may seem obvious, but this is a learned behavior that may prevent them from emotional growth in recovery. When there is a conflict or stress, they use, thereby avoiding their feelings as well as dealing with the situation. They check out. This removes them from interacting in the family unit or at work and creates ongoing dysfunction in many areas of their lives. Most of these people did not learn and were not supported in developing healthy coping skills in their formative years. This avoidance is one of the causes of the “Rip Van Winkel Effect”, which describes what happens when drug users are absent from important parts of their lives, sometimes for years. (Please see a separate paper that I recently wrote on this important concept.)

Another factor is self-medication of anxiety. This is an important factor in the initiation of drug use and certainly in its maintenance. They get used to the cycle of anxiety, self-medication, withdrawal, which then causes more anxiety. When in recovery any feeling of anxiety is interpreted as “need to use”.

For most of us anxiety is a reason to evaluate what is happening in our lives and dealing with the source, not for immediately taking a pill or a drink. This is a hard lesson for a person in recovery to learn. It complicates medical treatment that is aimed at craving reduction. Most of these problems are seen with buprenorphine (Subutex/Suboxone) treatment of opiate addiction. This medication is used to first treat the opiate withdrawal syndrome and then to reduce cravings. Some patients find that it also treats their underlying anxiety. Patients often state that they feel “normal” for the first time in years. This is a boon for early treatment as it makes psychosocial intervention much more effective. Opiate users in recovery typically have a prolonged period of feeling depressed, anxious, and achy. This is due to the longer-term damage to their opiate receptors, both the Mu (the usual receptor that opiates stimulate), as well as the Kappa (another opiate receptor that is blocked by buprenorphine). With opiate withdrawal the Mu receptors become under stimulated, while the Kappa receptors go into overdrive. While the Mu receptors may readapt in days and weeks, the Kappa receptors can take a much longer time and are well covered by very small doses of buprenorphine. (It is beyond the scope of this article to go into detail on this subject. Please see another paper that I have written on this vital topic). This disorder is called the Post Acute Withdrawal Syndrome (PAWS).

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As the buprenorphine is reduced, some of the PAWS symptoms may recur and persist. Anxiety is prime example. Buprenorphine has a very long half-life, an average of 37 hours, so for most, daily dosing usually works well and certainly there is no need for multiple doses throughout the day. It is important to make sure that the dose of buprenorphine in the early recovery stages is kept high enough to avoid “valleys”. This dose is rarely over 16 mg. per day (two 8 mg. tablets). As the medication is reduced from these higher doses, symptoms are transient and mild, lasting a day or two. When the dose gets below 8 mg. it becomes harder as the Kappa receptors come into play. The dose has to be reduced very slowly and the reduction should only proceed while the patient has maximal social support.

Other Factors:

It is also important to note the many of these people have a significant underlying anxiety problem or are even bipolar. They need medical or psychiatric treatment, in addition to the dependence-oriented groups that are so common in treatment programs. If someone was anxious before they got addicted and used opiates, at least in part, to self-medicate, several years of drug abuse and then drug withdrawal is not going to cure the problem. There are many ways to treat these problems without the use of addicting medications. Specifically, the use of benzodiazepines (Valium, Ativan, Klonopin, Xanax) should be avoided if at all possible. If they absolutely must be used, longer acting medication, such as Klonopin, taken on a set schedule and not in response to symptoms helps avoid the “feel bad—take a pill” problem. Many opiate addicts also are dependent on this class of drugs. Withdrawal from benzodiazepines causes severe anxiety and can be dangerous as seizures are possible. If this is the case a strategy to deal with this problem is vital.

This information is important as background for how to treat patients in these situations. First, we know that they will have some anxiety and second we know that if they are on the correct dose of buprenorphine and do not have a withdrawal problem with benzodiazepines or an underlying anxiety disorder, it is not caused by too little medication.

Treatment Approach:

I find that many of these patients use buprenorphine to medicate their anxiety or anger. They take it when they fell bad. Sometimes this causes them to over use the medication, something that should be picked up at any regular medical visit and addressed immediately. Other times it takes the form of dividing up the dose so that they have some when they get stressed. This is a real problem for their recovery as it simulates their prior drug use and even more important, also allows them to avoid dealing with life problems and learning how to deal with their feelings successfully.

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The best way to view this is to compare taking buprenorphine to taking blood pressure or anti depressant medication, which you take on schedule without expecting to “feel” any different. This is very difficult for substance abusers. As I have become aware of this tendency, I am asking my opiate patients who take buprenorphine to take the dose all in the morning or before bed. At the most, they should take the medication twice a day, the same time everyday. Again, this takes time and education. At every visit I ask specifically about how they take their medication and reiterate the importance of scheduled dosing. I ask not only my drug dependence patients, but my pain patients, “What are you feeling when you take you medication?” the answers can give insight into what changes are needed for growth and what dangers that specific person has in their treatment and recovery.

This alone is not enough. Leaving a person who is struggling with daily life, anxious or angry and removing their coping mechanism can lead to non-compliance, drop out from treatment, and relapse. I tell my patients that feeling anxious is a normal part of life and that when I have conflict or stress, I also have anger or anxiety, but I do not run to take a pill or a drink. So what do I do? What does anyone do?

The next step is to discuss choices that we all make everyday. Whenever we react to or initiate an action we go through a list of possible options. What do I want for breakfast? What do I wear? I call this choosing from “The Menu”. They have to get to the place where certain choices are simply “Off the Menu”. How you get to this point is complex and different for each person. This is why individual therapy is so important.

I tell them to “use” the anxiety or other feeling to find out what is troubling them. They can then deal with it instead of avoiding it. It is normal to be angry or anxious at times. Many people use these feelings as a source of energy to deal with difficult situations and tasks. Once this process starts emotional growth can flourish.