Methadone Is Not a Wonder Drug

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PS300: Research Methods I
Methadone is a synthetic opioid used in the treatment of heroin addiction, and even though there have been documented recoveries using Methadone, many people in the healthcare and psychology community believe that Methadone alone cannot cure heroin addicts; true medical treatment requires more robust treatment plans. Once touted as the wonder drug, methadone can cause as many problems as it solves; for instance, large numbers of people become addicted to methadone. The National Drug Prevention Alliance stated that methadone is 97% ineffective and has a success rate of no more than 3.4% (National Drug Prevention Alliance).

In this meta-analysis of Methadone treatment, four articles from the Kaplan University Library PsychARTICLES database will be assessed for the practicality of standard methadone treatments versus methadone treatments plus supplemental measures. These extended treatments are hypothesized to reduce the treatment time and prolong abstinence. The position of this essay is that standard methadone treatments only extend drug dependency and have an extremely high failure rate. Furthermore, for heroin addicts to successfully be cured from heroin addiction, other drug therapies and additional psychological and psychiatric maintenance is required to shorten methadone treatment plans and increase abstinence rates. In review of the selected articles, the analysis of the first two articles will offer a scientific summary about the positive outcomes of standard treatment. The assessment of the second two research articles will establish that more comprehensive methadone treatments have improved abstinence rates and reduce treatment times. Further analysis will follow after the brief summary of the articles.

The first article, Methadone maintenance improves cognitive performance after two months of treatment, from Experimental and Clinical Psychopharmacology, shines a positive light on standard methadone treatments; standard, meaning no other drug therapies or
psychological assistance programs were provided. The research strategy utilized in this particular study was the quasi-experiment model. It was selected because of the lack of total randomization, and its ability to employ the scientific method to accumulate data and analyze results. The design of the study was to measure the cognitive benefits from methadone treatment. Seventeen opiate-dependent subjects were selected to participate in this study. Each of the subjects was administered pre-assessment tests to establish a baseline. Once the subjects had started the drug treatment regimen, they did indeed show improvements in verbal and visuospatial encoding and memory recall (Gruber & Silberi & Renshaw & Tzilos & Plack & Kaufman, 2006). Thus, the results suggest that standard methadone treatments, not only reduce drug dependency, but also have other psychological benefits, namely cognitive performance.

The second article, *Exposure to opioid maintenance treatment reduces long-term mortality*, from Society for the Study of Addiction, discusses a ten-year longitudinal study on reduced mortality rates associated to standard drug treatments using methadone and buprenorphine (another synthetic opioid); we will only focus on the methadone treatments, as this is relative to the overall theme of this essay. This particular study was chosen due to the nature of the study; primarily a time lapse study. The data from the timeline suggests that exposure to opioid treatments can and will reduce the mortality rates in opioid dependent addicts. The mortality rate of non-treated, heroin-dependent addicts is 63 times that of the general population; conversely, the mortality rate was 8 eight times lower just by administering methadone treatment (Gibson & Degenhardt & Mattick & Ali & White & O'Brien, 2008). The design of the study was setup around a randomized controlled trial of 405 heroin addicts (Gibson & Degenhardt & Mattick & Ali & White & O'Brien, 2008). The baseline measurements and data were acquired by accessing births, deaths, and marriage registries (Gibson & Degenhardt &
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Mattick & Ali & White & O'Brien, 2008). By the end of the study, the researchers did prove that methadone treatments lowered mortality rates.

In article 3, the contrasted perspective moves on to methadone and modified treatment plans that offer longer abstinence rates and reduced methadone treatment regimens. In the study *Implosive Therapy Treatment of Heroin Addicts During Methadone Detoxification*, from the Journal of Consulting and Clinical Psychology, a randomized experiment was performed to measure the effectiveness of implosive therapy. There were very similar dosages of methadone administered to 24 male heroin addicts (Hirt & Greenfield, 1979). The design of the experiment was based around implosive therapy, counseling, and a control group. The implosive therapy in this article was 12 treatments that were an hour long. Each of these sessions consisted of negative stimuli (like darkness, closed doors, and broken needles) that would be associated to drug use (Hirt & Greenfield, 1979). The implosive therapy group was the only group that was able to reduce their methadone usage (Hirt & Greenfield, 1979). Thus, in the end, the experiment proved that methadone treatments were less effective, and that modified treatment plans were more effective.

The fourth and final article *When Is Less Treatment Better? The Role of Social Anxiety in Matching Methadone Patients to Psychosocial Treatments*, from the Journal of Consulting and Clinical Psychology, was about researchers recognizing that not all people are the same; some are more anxious and would benefit from tailored, less intense programs that would address patient anxiety (as well as their addiction). This was a randomized clinical trial where 307 opioid-dependent patients entered into two groups, one high intensity (the normal method), and one low intensity. The low intensity group would not receive set doses of methadone; they would receive doses based upon patient need. The patients would also receive coping skills
training to deal with their anxiety (Avants & Margolin & Kosten & Rounsaville & Schottenfeld, 1998). As the researchers had hypothesized, there were better treatment outcomes associated to the group that received coping skills and immediate attention to the patient’s needs. Thus, once again, confirming that modified methadone treatment plans seem to work much better than methadone treatment alone.

In comparing the similar attributes of these articles, one particular component is utilized over and over again, and that is the scientific method. The scientific method directs each of the researchers to use a common set of tools that will help them define a problem, construct a hypothesis, create a research design, measure data, analyze that data, and then perform generalization (Frankfort-Nachimas & Nachimas, 2008, p. 18). These are the scientific principles that are necessary to maintain the integrity of each of these studies. The scientific method allows researchers and scientists to conduct studies and experiments in an industry standard way. Without the scientific method, there would be no general guidelines, and thus the research and science community would be less progressive (as it would take much longer to measure the validity of any given study). There were other commonalities as well. For instance, methadone was used in all of these studies. Each study had subjects or patients. Every study also compiled and assessed data. And finally, each study delivered evidence to support the hypothesis of the respective study.

There is also the contrasted perspective as well. If we place the first two articles and the second two articles in groups of their own, we can assess several differences between the groups. For example, in group one, there were no modified therapies utilized; group one used standard treatments with their subjects. In group two, modified drug therapies were successfully implemented and proven to render better results than methadone treatment alone. The main
issue with group one is that it lacks a holistic approach to treatment. In group two, there were substantial differences in the short term and long term effects that were the direct result of customized therapies. The outstanding differences were shorter methadone treatment plans and longer abstinence rates. Group two employed implosive therapies, provided coping skills training to anxious patients, and closely monitored the patients’ progress; and thus this approach delivered more solid treatment plans, that when compared to methadone treatment alone, had significantly better results.

In conclusion, Methadone is a controversial drug that has many negative attributes, including opioid dependency. Because the standard methadone treatment has an extremely high failure rate, drug treatment plans need to incorporate therapies that are tailored to the patient, and not just utilize rigid, normal drug treatment regimens. A holistic approach to medicine and treatment will provide better short-term and long-term effects for the patient; it will lessen methadone treatment times and increase abstinence rates. For the researchers and psychologists of tomorrow, this data is extremely important because it will provide them with information and concrete studies to build on. Further research studies can be designed around the idea that modified drug treatments are indeed more beneficial than methadone treatments alone. The results of this meta-analysis are exactly what future researchers and psychologists can use to leverage against opioid addiction. And, as a final thought, if you or someone you knew were a recovering addict, which type of treatment would you choose?
References


