

AN OVERVIEW OF ADDICTION AND ADDICTION TREATMENT WITH A SPECIAL  
FOCUS ON THE OPIOID EPIDEMIC

BY

WILLIAM RUSSELL SCOGGINS

A THESIS SUBMITTED TO THE FACULTY IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF MASTER OF DIVINITY

DR. BRANDON HAYES, ADVISOR  
WISCONSIN LUTHERAN SEMINARY  
MEQUON, WISCONSIN

MARCH 7, 2018

## Abstract

For at least 20 years the United States has been in the midst of a severe opioid problem. The problem escalated rather gradually at first, but in the last 10 years it has grown significantly. With the current state of the opioid epidemic, it can be assumed that most pastors will have to deal with opioid abuse at some point in their ministry. This paper will educate the reader about the opioid epidemic. It will (1) give a brief history of some commonly abused substances, (2) look at history and the present state of today's opioid epidemic, (3) briefly consider both the scientific and spiritual components of addiction, (4) lay out and evaluate the treatment options available for those struggling with addiction, and (5) conclude with some general considerations. Addiction—whether addiction to alcohol, cocaine, or heroin—has some basic similarities. Therefore, this paper will at times speak about addiction in a general nature and at times speak specifically about opioid addiction. It should be noted that the evaluation of treatment options may be a useful introduction to treating addiction in general—not only opioid addiction. This paper also will seek to (A) bring to light a number of behaviors and actions from well-intentioned loved ones that may do more harm than good for an addict, and (B) name a number of societal and religious mindsets/stereotypes that are harmful and counterproductive in helping the addict recover.

## CONTENTS

INTRODUCTION .....	1
CHAPTER I - A BRIEF HISTORY OF COMMONLY ABUSED SUBSTANCES.....	3
Alcohol	3
Stimulants	4
Hallucinogens	6
Opiates	7
CHAPTER II - THE PROBLEM TODAY.....	9
Liberal Prescribing Practices	9
Pharmaceutical Companies	11
Pill Mills	14
Today's Statistics	17
Institutional Response	22
CHAPTER III - UNDERSTANDING ADDICTION.....	24
The Scientific Component of Addiction	25
The Spiritual Component of Addiction	27
CHAPTER IV - TREATING ADDICTION.....	33
The Fractured State of Addiction Treatment	33
Interventions	35
Detox	37

Primary Treatment	39
OTHER CONSIDERATIONS.....	43
An Evaluation of 12-Step Programs	43
Resilient Recovery	46
Preventing Opioid Addiction	46
CONCLUSION.....	48
APPENDIX 1.....	49
BIBLIOGRAPHY.....	51

*Forty-four percent [of Americans] say they personally know someone who has been addicted to prescription painkillers; a majority of Americans say that lack of access to care for people with substance abuse issues is a problem.<sup>1</sup>*

## INTRODUCTION

“What has been will be again, what has been done will be done again; there is nothing new under the sun” (Ecclesiastes 1:9). These words come from Solomon, the wisest man to ever have lived. In today’s world a similar adage is well known: “History repeats itself.” The applications for such sayings are far-reaching. They apply even to addictive chemicals and dependency. The potential to abuse a mind-altering substance has existed for as long as mind-altering chemicals have been known to man. Whenever a new drug is discovered in the medical community, abuse and dependency are sure to follow. Dependency on chemicals is not a new problem in the world. Although the opioid epidemic that America is experiencing may not be a “new” problem, it is a more serious manifestation of the age-old problem of addiction.

The word *addiction* is derived from the Latin word *addictio*. In Roman law, *addictio* was the giving up of a debtor to his creditor by a magistrate until the debtor's debts could be paid. The one enslaved because of his debts was called the *addictus*. The word *addiction*, as we know it today, has taken on a different meaning—the only similarity that remains is that addiction involves one being “given-over” to something. Shakespeare is thought to be the first recorded writer to use the word “addiction” in his play *Henry V*. Shakespeare's use of the word, and the use of it in the centuries that followed, held a rather neutral meaning of something that was a

---

1. Firth, Jamie, Kirzinger, Ashley, and Brodie, Mollyann, “Kaiser Health Tracking Poll: April 2016 - Substance Abuse and Mental Health,” *The Henry J. Kaiser Family Foundation*, April 2016, <https://www.kff.org/report-section/kaiser-health-tracking-poll-april-2016-substance-abuse-and-mental-health/>.

“strong inclination.” Only within the last century has the term “addiction” or “addict” come to mean what we know it as today.

Psychology Today gives an apt definition of the word “addiction” as it is used in today’s medical community:

“Addiction is a condition that results when a person ingests a substance (e.g., alcohol, cocaine, nicotine) or engages in an activity (e.g., gambling, sex, shopping) that can be pleasurable but the continuation of which becomes compulsive and interferes with ordinary responsibilities and concerns, such as work, relationships, or health. People who have developed an addiction may not be aware that their behavior is out of control and causing problems for themselves and others.”<sup>2</sup>

Although today's meaning behind the word addiction is fairly new, addiction has been talked about in the medical community for hundreds of years. The use of the word “addiction” in today’s medical community has replaced older terms like “inebriety”, “habitual”, and “mania” that had a similar meaning.

It is true: addiction is no new problem in the world—neither is it a new problem in America. Yet, as we will see, today’s opioid epidemic is worse than previous drug epidemics. In addition, the current services in place for treating addiction are inadequate. This paper seeks to also be a guide for those who struggle with addiction or those who are trying to help a loved one that struggles with addiction.

---

2. Psychology Today, “Addiction,” n.d., <https://www.psychologytoday.com/basics/addiction>.

## CHAPTER I - A BRIEF HISTORY OF COMMONLY ABUSED SUBSTANCES

Drug problems in America come and go in waves. For each wave of drug abuse, the abused substance may differ. I will give a few examples of drugs that have been abused in America during in the last 150 years to show evidence of this pattern. We will consider the history of alcohol, stimulants, hallucinogens, and opiates. The lists of specific drugs in the following sections—especially regarding stimulants, hallucinogens, and opiates—are by no means exhaustive.

### **Alcohol**

“The use of chemicals to alter thinking and feeling is as old as humanity itself, and alcohol was probably one of the first substances used for that purpose. Even the earliest historical writings make note of alcohol consumption, and breweries can be traced back some 6,000 years to ancient Egypt and Babylonia.”<sup>3</sup> In the middle ages Arab technology introduced the process of distillation, which increases the alcohol content in beverages. Alcohol also is the one drug that is spoken of in Scripture. Although the word addiction is never explicitly mentioned, the concept is present. Proverbs 23:31-32 holds an implicit warning about alcohol’s potential for abuse, “Do not gaze at wine when it is red, when it sparkles in the cup, when it goes down smoothly! In the end it bites like a snake and poisons like a viper.” To court alcohol—to have a relationship with it—is dangerous. Proverbs warns against this. Do not gaze at wine. Do not look at it longingly. Do not have a relationship with it. Those who have a prolonged and problematic relationship

---

3. Kuhn, Cynthia, Swartzwelder, Scott, and Wilson, Wilkie, *Buzzed: The Straight Facts About the Most Used and Abused Drugs from Alcohol to Ecstasy*, 4th ed. (New York, NY: W. W. Norton & Company, 2014), 35.

with alcohol might find themselves struggling with alcohol use disorder (AUD)—more commonly known as alcoholism.

While most drug problems in America come and go in waves, data suggests the rates of alcohol abuse have remained rather static, which may be the result of it being legal nationwide. Data regarding the harmful effects of alcohol is staggering. Consider the following statistics from the National Institute on Alcohol Abuse and Alcoholism<sup>4</sup>: An estimated 88,000 people die from excessive alcohol-use-related causes annually, making alcohol the third leading preventable cause of death in the United States. In 2010, alcohol misuse cost the United States \$249.0 billion. Three-quarters of the total cost of alcohol misuse is related to binge drinking<sup>5</sup>. Researchers estimate that each year: 696,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking, 97,000 students between the ages of 18 and 24 report experiencing alcohol-related sexual assault or date rape, and roughly 20 percent of college students meet the criteria for AUD. In 2015, almost 50 percent of all liver disease deaths involved alcohol abuse.

### **Stimulants**

America has faced challenges with various forms of stimulants over the past century. A stimulant is, “An agent that arouses organic activity, strengthens the action of the heart, increases vitality, and promotes a sense of well-being; classified according to the parts on which it chiefly acts:

---

4. All statistics come from National Institute on Alcohol Abuse and Alcoholism and can be found at: <https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics>

5. Binge drinking, as defined by the National Institute on Alcohol Abuse and Alcoholism is a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dL. This typically occurs after 4 drinks for women and 5 drinks for men—in about 2 hours.



cardiac, respiratory, gastric, hepatic, cerebral, spinal, vascular, or genital.”<sup>6</sup> Examples of stimulants include: caffeine, cocaine, methamphetamine and prescription drugs like Adderall and Ritalin.

The extracting of pure cocaine from the coca leaves was first discovered by German Scientist Albert Niemann in 1860. In the late 1800s and early 1900s cocaine was used in numerous “tonics” and unofficial medicinal recipes in the United States. The number of addicts and abusers grew steadily in the early 1900s until the harmful effects of cocaine were noticed and cocaine was outlawed under the Harrison Narcotic Act in 1914. Use of cocaine diminished throughout the following decades until a resurgence in the 1970s. Cocaine would later be used to create crack-cocaine—or simply “crack”—which would cause more serious problems than cocaine. Crack is made by mixing water, sodium bicarbonate, and cocaine. The mixture is boiled until a solid is formed—crack. This new compound is smoked causing it to enter the bloodstream more quickly. The high is more intense than that of cocaine; it is also more addictive and more dangerous.

Amphetamine and related drugs have a similar story. Amphetamine was discovered in 1887 and became popular in the 1930s. Soldiers from many countries including Germany, Japan, and the United States used amphetamine during World War II. After World War II amphetamine and methamphetamine (or “meth”) use spread more widely into civilian populations. Episodes of abuse of these highly addictive stimulants have occurred ever since. In 2006, law enforcement personnel in the United States listed meth as the number one drug problem they faced. Although

---

6. *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health*, s.v. “Stimulant.” Retrieved October 8, 2017 from <https://medical-dictionary.thefreedictionary.com/stimulant>.

drug problems of the past have been devastating, based on the number of overdoses, today's opioid epidemic is more severe than any past epidemics.<sup>7</sup>

### **Hallucinogens**

A hallucinogen is a drug that changes one's perception of the world by temporarily altering perception, thoughts, emotions and consciousness. Drugs in this category include psychedelics (examples: LSD<sup>8</sup>, mushrooms, DMT<sup>9</sup>, and peyote), dissociatives (examples: ketamine, nitrous oxide, dextromethorphan based cough syrup, and PCP<sup>10</sup>), and deliriant (a number of delirium inducing plants and prescription medications fall into this category). A number of hallucinogens have a history of medical and religious use.

The history of such drugs is as wide ranging as the quantity of drugs themselves (hundreds of drugs fall into this category). Generally speaking, hallucinogens that are found in nature have been used for quite some time. For example, the naturally occurring peyote and psychedelic mushroom have been used for religious and medicinal purposes for thousands of years. Drugs that are produced in labs generally have a shorter history. For example, LSD was first synthesized in 1938 by chemist Albert Hoffmann. Throughout the 1950s and early 1960s a number of hallucinogenic drugs had a place in the medical world and were used alongside therapy. In the late 1960s and early 1970s, as these drugs became more widely used by the general populations, they became associated with youthful rebellion, social dissent and political

---

7. Regier, Paul, "Drug Epidemics: Now and Then," *Addiction Unscripted*, 4 April 2016, <https://addictionunscripted.com/drug-epidemics-now-and-then/>.

8. "LSD" or "acid" is the commonly used name for Lysergic acid diethylamide.

9. "DMT" is the commonly used name for N,N-Dimethyltryptamine.

10. "PCP" is the commonly used name for Phencyclidine.

upheaval. Subsequently, laws were passed against their recreational and scientific use in the 1970s which led to a reduction in their abuse.

More recently, hallucinogens have begun to make a comeback. Scientific and medical research about the usefulness and safety of these drugs is again being undertaken. Additionally, a number of hallucinogenic drugs have made their way back into mainstream—and even professional—culture through “microdosing”. Microdosing is the act of taking a small dose—somewhere between 1/10 to 1/100 of the amount it takes to produce hallucinogenic effects—of drugs like LSD or mushrooms. Taking these drugs in small amounts is thought to increase productivity, creativity, and problem solving skills.

The addiction potential of these drugs is somewhat debated and varies from drug to drug. As a result of how they act in the brain, it is thought that the addiction potential of drugs like LSD and psychedelic mushrooms are relatively low; however, drugs like PCP are considered to be extremely addictive.

### **Opiates**

This category of drugs is of particular interest to this paper since the United States’ current opioid epidemic is a primary focus. There is a distinction between opiate and opioid. An opiate is “any of various analgesic, narcotic drugs derived from the opium poppy, such as morphine or codeine.”<sup>11</sup> Opiates are drugs that are derived from the naturally occurring alkaloids in the opium poppy plant. Most opioids are similar to opiates in that they are partially derived from the poppy plant or produce similar opiate-like effects. Some opioids like fentanyl are not derived from

---

11. *Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, s.v. “Opiate.”* Retrieved October 8, 2017 from: <https://medical-dictionary.thefreedictionary.com/opiate>

opium at all; they are entirely synthetic. Today, opioids are a pillar of pain-treatment in the medical community.

The oldest historical references to the medicinal use of opiates are thousands of years old and come from the Sumerian and Assyrian/Babylonian cultures. Opium has been used in the United States throughout its history. Numerous waves of opiate and opioid epidemics have hit the United States in the last 150 years. In 1805 morphine—the most potent alkaloid in the opium poppy—was isolated. In 1853 Alexander Wood invented the hypodermic syringe which he used to inject his wife with morphine in an experiment. She died from respiratory depression—one of the side effects of opiates. The first wave of addiction due to injectable narcotics came as a result of the wide use of injected morphine during the American Civil War. In 1898 the scientists at the Bayer Company discovered that adding an extra chemical group onto morphine made it more soluble in fat, causing it to enter the brain faster. This advancement is known as heroin.

Fentanyl was first synthesized by Paul Janssen in 1959. It is estimated to be 50 times more powerful than heroin and 100 times more powerful than morphine. Since its creation, it has been extremely useful as a pain medication and a surgical anesthetic under proper medical use. However, over the past 10 years illegally sold and used fentanyl has led to numerous deaths. As dangerous and potent as fentanyl is, it far from being the most dangerous synthetic opioid.

## CHAPTER II - THE PROBLEM TODAY

There are a number of complicating factors that have led to today's opioid epidemic. Some of the most significant complicating factors include, liberal prescribing practices, misinformation, patient ignorance, and pharmaceutical companies.

### **Liberal Prescribing Practices**

It is estimated between 70%-80% of people who use heroin are first introduced to opioids through non-medical prescription medication use.<sup>12 13</sup> The history and danger of prescription opioids is therefore worthy of consideration. Misinformation about the power and addictiveness of prescription opioids has directly fueled today's problem. In 1986, Dr. Russell Portenoy published a study in the *Journal of Pain* that advocated for the long-term use of opioid medications. Dr. Portenoy's study had a number of assertions that led to more liberal prescribing practices. Specifically, his paper suggested that (1) previous fears regarding the addiction potential of prescription opioids were unfounded. (2) Addicts were born not made. (3) No dose is too high—if a particular dose stopped working, it was perfectly okay to increase the dose as high as it needed to be to begin working again.<sup>14</sup> Dr. Portenoy preached the results of his study to the world. He claimed concerns about addiction and abuse amounted to a medical myth. In an

---

12. National Institute on Drug Abuse, "Prescription Opioid Use Is a Risk Factor for Heroin Use," January 2018, <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use>.

13. Keefe, Patrick Radden, "The Family That Built an Empire of Pain," *The New Yorker*, 30 October 2017, <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>.

14. Portenoy, Russell K. and Foley, Kathleen M., "Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases," *PAIN* 25.2 (1986): 171, [http://journals.lww.com/pain/Abstract/1986/05000/Chronic\\_use\\_of\\_opioid\\_analgesics\\_in\\_non\\_malignant.4.aspx](http://journals.lww.com/pain/Abstract/1986/05000/Chronic_use_of_opioid_analgesics_in_non_malignant.4.aspx).

interview with the New York Times he stated, “There is a growing [amount of] literature showing that these drugs can be used for a long time with few side effects, and that addiction and abuse are not a problem.”<sup>15</sup> He also received funding from Purdue Pharma—a company that will be discussed later—and publically denounced doctors that were slow to use opioids, saying they had “opiophobia”. At first, many doctors remained hesitant to liberally prescribe opioids as Dr. Portenoy suggested; however, a few mavericks immediately stepped forward and adopted the methods. Over the next 10 years, much of the industry would follow and adopt moderate to liberal prescribing practices.

One of the first, most prominent, and most controversial mavericks to jump aboard with these loose prescribing practices was Dr. William Hurwitz. Dr. Hurwitz recklessly followed the suggestion of Dr. Portenoy: increase the dosage without fear—achieve pain relief for the patient at all costs. On average, he prescribed patients 70 pain pills a day. On the high end of the spectrum he would prescribe as many as 150 pills a day. On principle, the doctor decided not to judge his patients or be skeptical of them but to merely treat the pain that patients told him they had. There are numerous testimonies of people who were able to lead normal lives again thanks to Dr. Hurwitz’s loose prescribing practices. On the other hand, it was so easy to get pills from him that a number of his patients became drug dealers. Eventually his practice came under scrutiny because a number of his patients died. In the late 1990s and early 2000s police began to arrest oxycodone dealers only to find that a number of them were getting their medication from Dr. Hurwitz. Some of the dealers worked with police to secretly record Dr. Hurwitz; this eventually led to his arrest and incarceration. In 2004, Dr. Hurwitz was convicted of over 50

---

15. Rosenthal, Elisabeth, “Patients in Pain Find Relief, Not Addiction, in Narcotics,” *The New York Times*, 28 March 1993, <http://www.nytimes.com/1993/03/28/us/patients-in-pain-find-relief-not-addiction-in-narcotics.html>.

counts of narcotics distribution and received a 25-year prison sentence. The verdict was overturned after an appeal. After a 2nd trial he was convicted of 16 lesser charges and eventually released after serving four years and eight months in prison. While doctors like Dr. Hurwitz led the charge with liberal prescribing practices, other factors caused the problem to become more widespread and severe: Purdue Pharma's flagship opioid OxyContin and pill mills.

### **Pharmaceutical Companies**

OxyContin—at the time a powerful new opioid—was invented in 1995 by Purdue Pharma. OxyContin was designed to be an extended release<sup>16</sup> form of oxycodone. It was hailed as a medical breakthrough and was more powerful than morphine. In its first year OxyContin accounted for \$45 million in sales. Four years later, sales hit \$1.1 billion. 10 years later, sales hit \$3.1 billion. An article from the Los Angeles Times shows the impact of Purdue Pharma and their drug OxyContin, “Before OxyContin, doctors had viewed narcotic painkillers as dangerously addictive and primarily reserved their long-term use for cancer patients and the terminally ill. Purdue envisioned a bigger market.”<sup>17</sup> Purdue pushed this drug hard and succeeded in reaching a bigger market. They targeted physicians through their advertising and marketed their drug as the one-pill-fix for any and every pain related problem. Doctors were

---

16. Purdue Pharma's claimed and continues to claim that their medication—as advertised—provides 12 hours of continual pain relief. Numerous patients and doctors have questioned the effectiveness of this extended release technology. An investigation by the Los Angeles times claims that Purdue Pharma executives knew that the claim of providing 12 hours of continual pain relief was questionable at best. Rather than investigate claims and change their position, Purdue Pharma insisted that the dose needed to be raised rather than adjusting the frequency of taking medication.

17. Harriet, Ryan; Girion, Lisa; and Glover, Scott, ““You Want a Description of Hell?’ OxyContin’s 12-Hour Problem,” *Static.Latimes.Com*, n.d., <http://www.latimes.com/projects/oxycotin-part1/>.

offered all-expenses-paid trips so they might attend Purdue pain seminars.<sup>18</sup> In addition, Purdue spread misinformation about the addictiveness of OxyContin, suggesting that it was no concern. Purdue had conducted no clinical studies on how addictive or prone to abuse OxyContin actually was, yet the Food and Drug Administration (FDA) approved a package insert that stated the drug was safer than other painkillers because the patented delayed-release mechanism was “believed to reduce the abuse liability”.<sup>19</sup> A short time later, the FDA examiner who oversaw the process left the agency. Within two years he had taken a job at Purdue Pharma. Purdue’s aggressive promoting and defense of their drug exacerbated the drug’s abuse.<sup>20</sup> Their drug and the marketing of it brought about an “impact on the practice of medicine [that] was...transformative. Other drug companies began marketing their own narcotic painkillers for routine injuries. By 2010, one out of every five doctor’s visits in the U.S. for pain resulted in a prescription for narcotic painkillers.”<sup>21</sup>

The abuse potential for OxyContin was extremely high. With little effort, every strength dose could be crushed and snorted, or mixed with water, drawn into a hypodermic syringe and injected directly into the bloodstream. Snorting or injecting OxyContin caused the user to experience the entire high immediately rather than receive pain relief over time. Purdue Pharma eventually had to face some of the consequences of their actions. Hundreds of lawsuits were brought against Purdue. Very few brought any favorable results as the drug maker was committed to winning at all costs. At the one point, Purdue was spending \$3 million a month in

---

18. “The Family That Built an Empire of Pain,” Keefe.

19. “The Family That Built an Empire of Pain,” Keefe.

20. United States General Accounting Office, *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*, Report to Congressional Requesters, December 2003.

21. “‘You Want a Description of Hell?’ OxyContin’s 12-Hour Problem.” Harriet, Girion, and Scott.



legal bills. However, in 2007, Purdue finally lost a criminal case. The district of US attorney John Brownlee of Roanoke, Virginia, a region of the country that had been devastated by pharmaceutical painkillers, successfully prosecuted drug dealers and doctors and finally decided to investigate the source of the problem. As a result of the investigation Purdue pleaded guilty to federal criminal charges that it had lied about the drug's risk of addiction. "Three top executives paid \$34.5 million in fines and the company paid \$600 million, one of the largest such fines ever paid by a pharmaceutical company."<sup>22</sup> Rightly so, Purdue continued to be plagued with legal battles over the false advertising of OxyContin. In December of 2015 the company settled a long running legal battle with Kentucky—a state that was hit particularly hard by the oxycodone epidemic. In regard to this case, "Some thought damages could be billions of dollars. Purdue agreed to pay \$24 million but admitted no wrongdoing."<sup>23</sup> Although Purdue has refused to admit wrongdoing, the company seems to have undergone a slight shift of conscience. In 2010 Purdue quietly began distributing a new abuse-resistant form of their popular OxyContin. In addition, they offered Florida \$1 million to aid in establishing a drug database that would help regulate prescriptions.<sup>24</sup>

Purdue Pharma, nor other opioid producing pharmaceutical companies, are legally off the hook yet. A number of lawsuits have been filed against them in recent months as people look for

---

22. Temple, John, *American Pain: How a Young Felon and His Ring of Doctors Unleashed America's Deadliest Drug Epidemic* (Guilford, CT: Rowman & Littlefield, 2015), 50.

23. Peterson-Withorn, Chase, "Fortune of Family Behind OxyContin Drops Amid Declining Prescriptions," *Forbes*, n.d., <https://www.forbes.com/sites/chasewithorn/2016/06/29/fortune-of-family-behind-oxycotin-drops-amid-declining-prescriptions/>.

24. *American Pain*, Temple, 245.

someone to blame over today's opioid epidemic.<sup>25</sup> The Los Angeles Times summarizes the impact of Purdue Pharma's OxyContin, "Over the last 20 years, more than 7 million Americans have abused OxyContin, according to the federal government's National Survey on Drug Use and Health. The drug is widely blamed for setting off the nation's prescription opioid epidemic, which has claimed more than 190,000 lives from overdoses involving OxyContin and other painkillers since 1999."<sup>26</sup>

### **Pill Mills**

One more factor worth noting is the history of "pill mills" as they too have played a role in the state of today's opioid epidemic. A pill mill is a shady medical practice whose main focus is dealing out prescription narcotics like OxyContin, morphine, and Xanax. Pill mills were rampant in Florida, Texas, and a number of states on the East Coast between 2007-2010 and operated under the guise of "pain clinics". Florida was the most notorious for its hundreds of pill mills. Often times, the owners of pill mills knew little about actual medical practice. Their main concern was making money—not the wellbeing of patients. Owners of pill mills would hire doctors who either approved of the shady practices or acted like they did not know what was going on. The doctors would write prescriptions for hundreds of pills for almost anyone that walked through the door. The waiting rooms of most pill mills were full of addicts.

Since laws were not consistent nationwide, obtaining large amounts of prescription narcotics was easier in some states and more difficult in others. Florida was the easiest place to

---

25. Semuels, Alana, "Are Pharmaceutical Companies to Blame for the Opioid Epidemic?," *The Atlantic*, 2 June 2017, <https://www.theatlantic.com/business/archive/2017/06/lawsuit-pharmaceutical-companies-opioids/529020/>.

26. "“You Want a Description of Hell?’ OxyContin’s 12-Hour Problem.” Harriet, Girion, and Scott.

get prescription narcotics. Addicts would drive across state borders to go to these “pain clinics” (pill mills) and pay for hundreds of pills in cash. Interstate 75 between Kentucky and Florida became known as the “oxy express” due to the high number of addicts that would drive the route to obtain large prescriptions of OxyContin. One of the most infamous pill mills was the South Florida pain clinic known as, “American Pain.”

American Pain was the brainchild of Chris George, Jeff George, and Derek Nolan. Chris George opened his first pain clinic in south Florida in February 2008. Due to rapid growth, logistical problems, annoyed neighbors and police hounding, he moved his operation a number of times and opened numerous pain clinics before the entire operation was permanently shut down on March 3, 2010. During those two years, his operation brought in an estimated \$40 million dollars.<sup>27</sup> Between July 2008 and March 3, 2010 the doctors of his various pain clinics wrote 66,871 prescriptions. Ninety-six percent of those prescriptions were for oxycodone or alprazolam (brand name: Xanax). More than 80% of patients served there were from out of state. 43% of the prescriptions went to patients from Kentucky, 20% to patients from Florida, 18% to patients from Tennessee, and 11% to patients from Ohio.<sup>28</sup> As was typical with the owners of pain clinics in Florida, Chris had no medical experience or expertise. He simply learned how to run an enterprise, call drug wholesalers to order prescription narcotics, hire doctors who prescribed medication liberally, and conduct damage control when the actions of the addicts he enabled inevitably came back to haunt him and the clinic. Those who came to the pain clinic would pay both for the visit and prescription in cash. They often were able to fill their prescriptions onsite. Chris George, all those who worked in partnership with him, and all those

---

27. “American Pain,” n.d., <http://johntemplebooks.com/books/american-pain/>.

28. *American Pain*, Temple, 234-235.

who worked for him (except for two doctors) were eventually tried, convicted, and sentenced to various lengths of prison time.

Bringing down Chris George's operation was a slow yet successful endeavor. In 2010, ninety of the top one hundred oxycodone-purchasing doctors in the U.S. lived in Florida. By 2010, only one did. The number of oxycodone pills shipped to Florida dropped from 650 million in 2010 to 313 million in 2013. In roughly the same time frame, the number of pain clinics dropped from over 1000 to less than 400.

One little-known, yet very significant, wrinkle in the history of the opioid epidemic (and in the problem we face today) is that it is the duty of the Drug Enforcement Administration (DEA) to decide how much of each controlled substance is to be manufactured every year. This means the DEA has the power to reduce the amount of narcotic drugs that are produced for medicinal and scientific purposes. This process takes place on a yearly basis. Again, the DEA shares responsibility for the amount of prescription medications made available. In 1993, three years before Purdue Pharma released OxyContin, the DEA allowed pharmaceutical companies to manufacture 3,520 kilograms of oxycodone.<sup>29</sup> By 2007, the DEA signed off on the production of 70,000 kilograms. As the nation's oxycodone problem worsened, the DEA allowed larger and larger amounts of the drug to be produced. By 2010, the DEA signed off on 105,500 kilograms. In 2017, they signed off on 101,500 kilograms.<sup>30</sup> In 2017, the amount of oxycodone that was produced was hardly lower than the amount produced when the oxycodone epidemic was at its worst in 2010.

---

29. *American Pain*, Temple, 52.

30. Diversion Control Division, *2018 Aggregate Production Quota History for Selected Substances* (U.S. Department of Justice - Drug Enforcement Administration, November 15, 2017), [https://www.deadiversion.usdoj.gov/quotas/quota\\_history.pdf](https://www.deadiversion.usdoj.gov/quotas/quota_history.pdf).

Pill mills may not be as prevalent throughout the United States today as they were in Florida from 2007-2010, but they still exist and they are still a problem. A Google search for “pill mill busted,” will yield numerous—and recent—results and news stories. They are not concentrated and running rampant like they were in Florida. The doctors of today’s pill mills are more careful and not as flamboyant. Yet similar quantities of pills are being distributed nationwide. The amount of oxycodone (along with other highly addictive opioids) that is being produced has hardly been reduced. In some cases it has not been reduced. Those medications are ending up somewhere and being given to someone. An addict will find access to mind altering chemicals—whether in Florida or Alaska, on the street or in a doctor’s office.

In many ways, it was a perfect storm that led to the state of today’s opioid epidemic. Between loosening prescribing practices, Purdue Pharma’s OxyContin, and pill mills, much of the country was hit hard—the amount of prescription drug abuse, the number of addicts, and the rates of drug overdose soared in direct correlation to the availability of prescription opioids. This is a history that should not be separated from today’s problem. These problems have changed the mindset of the American people. To conclude this chapter, we will take a look at some statistics that give a picture of America’s changed and dangerous attitude regarding prescription medication. We will consider some statistics that show the gravity of today’s opioid epidemic.

### **Today’s Statistics**

Opioid abuse, prescription abuse, and drug overdose are as big of a problem as they have ever been. In a 2011 fact sheet from The American Society of Interventional Pain Physicians it was estimated that, “Americans, constituting only 4.6% of the world’s population, have been consuming 80% of the global opioid supply, and 99% of the global hydrocodone supply, as well

as two-thirds of the world’s illegal drugs.”<sup>31</sup> Is this a difficult statistic to nail down for sure? Yes, it is. Yet it is staggering nonetheless. The International Narcotics Control Board (INCB) has a more recent estimate. Using 2015 data, they estimate that the population of the United States of America makes up 4.8% of the world’s population, yet uses 49.6% of the world’s yearly morphine that is produced.<sup>32</sup> Most of this morphine is used for conversion into other opiates like codeine. The INCB has a number of other statistics that help us see the gravity of America’s disposition to opioids. For the following statistics, it is worth reiterating that the United States accounts for a mere 4.8% of the world’s population. In 2015 the United States accounted for:

- 40% of the global thebaine<sup>33</sup> consumption
- 99.7 % of the global hydrocodone consumption
- 45% of the hydromorphone consumption
- 69% of the global oxycodone consumption
- 29.3% of the global fentanyl consumption
- 47% of the global ketobemidone consumption<sup>34</sup>

While these statistics are not quite as staggering as the estimate from The American Society of Interventional Pain Physicians—they still bring out a very significant point. America, a country that makes up a very small percentage of the World’s population, is the largest consumer of numerous opioids. America has an affinity for prescription opioids.

It is impossible to blame a single party for America’s taste for prescription painkillers. A National Safety Council survey found that 99% of doctors prescribe “highly addictive opioid

---

31. American Society of Interventional Pain Physicians, “The American Society of Interventional Pain Physicians (ASIPP) Fact Sheet,” 2012, <http://www.asipp.org/documents/ASIPPFactSheet101111.pdf>.

32. International Narcotics Control Board, *Narcotic Drugs: Estimated World Requirements for 2017, Statistics for 2015* (New York: United Nations, 2016).

33. “Thebaine itself is not used in therapy, but it is an important starting material for the manufacture of a number of opioids, mainly codeine, dihydrocodeine, etorphine, hydrocodone, oxycodone and oxymorphone” (The International Narcotics Control Board, *Narcotic Drugs*, 33.)

34. *Narcotic Drugs*, The International Narcotics Control Board, 41-52.

medicines for longer than the three-day period recommended by the Centers for Disease Control and Prevention (CDC).”<sup>35</sup> As such, part of the responsibility lies with doctors. Yet part of the blame also lies with the patients. Patients with pain expect to be given treatment that will fix the problem in the most simple way possible. The same survey says, “67% of doctors say patient expectations impact their decision to prescribe opioids,” and “54% of doctors say patient expectations are a barrier to prescribing alternatives to opioids.”<sup>36</sup>

Measures are being taken by the government to try and reign in America’s prescription opioid problem. In 2013, the FDA began requiring makers of extended release opioids (OxyContin) to include black-box warnings on pill bottle labels that warn users of the drug’s potential for abuse; In 2016, the FDA extended this requirement to all opioid painkillers; in March of 2017, the CDC issued new guidelines to physicians that recommend opiate painkillers be the last line of pain treatment in most cases.<sup>37</sup> There are a number of states that have passed laws that limit the amount of pills a patient may receive. The state with the strictest of laws is New Jersey. In New Jersey, there is a 5 day limit on opioid prescriptions. Laws and attempts like these at regulations from the federal and state government have been met with harsh opposition from many physicians who believe “doctors—and not the government—should decide how many pills to prescribe their patients.”<sup>38</sup>

Whether or not there is a correlation between the amount of prescription painkillers being prescribed and the amount of illicit drugs being used is debated; however, there *is* a correlation

---

35. National Safety Council, “99% of Doctors Prescribe Highly-Addictive Opioids Longer than CDC Recommends,” 24 March 2016, <http://www.nsc.org/Connect/NSCNewsReleases/Lists/Posts/Post.aspx?ID=108>.

36. Teater, Don, “Prescriber Attitudes and Behavior Related to Prescription Opioid Pain Medication,” 2016.

37. Marcovitz, Hal, *The Opioid Epidemic* (San Diego, CA: ReferencePoint Press, Inc, 2018), 44.

38. *The Opioid Epidemic*, Marcovitz, 48.

between the abuse of prescription painkillers and illicit drug use. The National Institute on Drug Abuse estimates that “52 million people (20 percent of those aged 12 and older) have used prescription drugs for nonmedical reasons at least once in their lifetimes.”<sup>39</sup> In addition, they suggest that “the incidence of heroin initiation [is] 19 times higher among those who reported prior nonmedical pain reliever use than among those who did not.”<sup>40</sup> The more prescription painkillers available (and the easier they are to get), the more potential there is for abuse—this was seen in the Purdue Pharma and pill mill narrative. A number of studies have suggested that the rise of governmental regulations and the increasing cost of prescription painkillers have led more and more nonmedical abusers to switch to street drugs that have become cheaper and more available; however, *The New England Journal of Medicine* questions the credibility of these claims and suggests an alternative theory:

The transition from nonmedical use of prescription opioids to heroin use appears to be part of the progression of addiction in a subgroup of nonmedical users of prescription opioids, primarily among persons with frequent nonmedical use and those with prescription opioid abuse or dependence. Although some authors suggest that there is an association between policy-driven reductions in the availability of prescription opioids and increases in the rates of heroin use, the timing of these shifts, many of which began before policies were robustly implemented, makes a causal link unlikely.<sup>41</sup>

While there are numerous stories of people who switched to heroin or fentanyl due to its decreased price and increased availability, as the *New England Journal of Medicine* points out, it is difficult to nail down price and availability of illicit drugs versus price and availability of

---

39. National Institute on Drug Abuse, *Prescription Drug Abuse*, Publication, Research Report Series (U.S. Department of Health and Human Services - National Institutes of Health, October 2011).

40. National Institute on Drug Abuse, “Prescription Opioid Use Is a Risk Factor for Heroin Use,” January 2018, <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use>.

41. Compton, Wilson M., Jones, Christopher M., and Baldwin, Grant T., “Relationship between Nonmedical Prescription-Opioid Use and Heroin Use,” ed. Longo, Dan L., *New England Journal of Medicine* 374.2 (2016): 154–63, <http://www.nejm.org/doi/10.1056/NEJMra1508490>.



prescription medications as fundamental reasons for the rise in heroin use. The Substance Abuse and Mental Health Services Administration has found a more accurate way to state a correlation between nonmedical prescription pain reliever use (prescription opioid abuse) and illicit opioid use: “Four out of five recent heroin initiates (79.5 percent) previously used nonmedical prescription pain relievers whereas only 1.0 percent of recent nonmedical prescription pain reliever initiates had prior use of heroin. However, the vast majority of nonmedical prescription pain reliever users have not progressed to heroin use.”<sup>42</sup>

An added danger that faces those who go from prescription opioids to street drugs is the unverifiable purity of street drugs. More often than not, manufacturers of street drugs “cut”—or add non-pure substances to—a particular drug that mimic the pure form of the drug. Often times, this is done to increase profit. When the purity of illicit street drugs like heroin are tested they are often found to contain any number of adulterants such as amphetamine, ecstasy, phenmetrazine, chlorpheniramine, dextromethorphan, pseudoephedrine, ketamine, cannabis, and fentanyl derivatives. While some of the adulterants found in street drugs can be less harmful than the actual drug itself, this is not always the case. When someone takes an illicit drug, it is difficult to know the purity of the drug without sending it into a lab to be tested. They may think they are taking a single substance when they are actually taking any number of things—some of which may be far more dangerous and addictive. There have been numerous cases of overdoses from people who have taken drugs that have fentanyl derivatives added to them.

The range of statistics and data regarding the opioid epidemic are vast, differentiating, and (in some cases) contradictory. Regardless of the differences, evaluating the dire statistics

---

42. Muhuri, Pradip K.; Gfroerer, Joseph C.; and Davies, M. Christine, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States* (Center for Behavioral Health Statistics and Quality - Substance Abuse and Mental Health Services Administration, August 2013).

makes one thing clear: America is in the middle of a serious opioid epidemic. Both illicit drug use and nonmedical use of prescription opioids present a serious problem for America—the magnitude of which it has not previously faced. This is a problem that pastors will have to handle—if not in the lives of their immediate families, then certainly in the lives of their members. To return to the quote found at the opening of this paper: “Forty-four percent [of Americans] say they personally know someone who has been addicted to prescription painkillers; a majority of Americans say that lack of access to care for people with substance abuse issues is a problem.”<sup>43</sup>

### **Institutional Response**

Although it is not the purpose of this paper to investigate the shortcomings of institutional response to addiction, it is worthwhile to recognize them. For the last half century, the response from government and insurance companies has only served to worsen the problem of addiction.

The government has responded to drug use and abuse by making harsher laws—people end up in prison rather than receiving the help and treatment they need. The time addicts have to reflect on their mistakes in prison does little to equip them to recover from addiction. Once their time has been served, they often return to the environment that caused them to use.

Insurance companies often refuse to pay for addiction treatment, or if they do pay, they only pay a small part or for a short length of stay. The National Center on Addiction and Substance Abuse at Columbia University estimates that more than 1 in 7 of the Americans over age 12 have an addiction to nicotine, alcohol, or other drugs—suggesting there are millions who

---

43. Firth, Jamie; Kirzinger, Ashley; and Brodie, Mollyann, “Kaiser Health Tracking Poll: April 2016 - Substance Abuse and Mental Health,” *The Henry J. Kaiser Family Foundation*, April 2016, <https://www.kff.org/report-section/kaiser-health-tracking-poll-april-2016-substance-abuse-and-mental-health/>.

could benefit from addiction treatment. However, many insurance companies have complicated sets of rules and guidelines when it comes to addiction treatment. These rules and guidelines vary from company to company. No addiction treatment should be assumed to be covered by health insurance. It would be beneficial for those dealing with addiction to call their health insurance to get specifics.

### CHAPTER III - UNDERSTANDING ADDICTION

Although it is (hopefully) a dying idea, the school of thought that says addiction should be treated as a purely spiritual matter is false. Not only is it false, it is damaging. In the 1930s, those who studied addictive behavior considered drug addicts to be morally flawed and lacking willpower.<sup>44</sup> This erroneous way of thinking has continued to plague society. It can be seen in Richard Nixon's declaration of war on drugs. Some characterize Nixon's declaration of war on drugs as a move to maintain White House power by targeting hippies and blacks. From this era came the perception that drug use and addiction is a moral failure or weakness. Drug use was met with criminalization and harsh judicial punishment. The message was clear: Those who use drugs, deserve prison. Even today, the idea of fighting drug use as though it is a war against criminals and degenerates has permeated government and society. It is no surprise that the idea of drug use and addiction being a moral failure has come out this era. Treating addiction as a moral failure that is to be met with the hammer of the law only makes the problem worse as the problem is never actually treated, it is merely condemned. "[The] stigma associated with drug use—the belief that bad kids use, good kids do not, and those with full-blown addiction are weak, degenerate, and pathetic—has contributed to the escalation of use and has hampered treatment more than any single other factor."<sup>45</sup> There is both a spiritual and a scientific component to treating addiction—neither should be undervalued or dismissed.

---

44. National Institute on Drug Abuse, "How Science Has Revolutionized the Understanding of Drug Addiction," *Drugs, Brains, and Behavior: The Science of Addiction*, July 2014, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.

45. Sheff, David, *Clean: Overcoming Addiction and Ending America's Greatest Tragedy* (Boston, MA: Houghton Mifflin Company, 2013), 25.

## The Scientific Component of Addiction

Science has taught us a lot about how addiction affects both brain and behavior. Addiction is a disease<sup>46</sup> of the brain. The following is a paraphrase of the National Institute on Drug Abuse's page on addiction and the brain:

The human brain is the most complex organ in the body. It is made up of many structures that work together as a team. Different parts are responsible for coordinating and performing specific functions. Drugs have the ability to alter important areas of the brain that are necessary for life-sustaining functions. For instance, drugs can alter the brainstem, which controls basic functions that are critical to life. They can alter the cerebral cortex, which helps us process information from our senses, helps us think, plan, solve problems, and make decisions. And finally, they can alter the limbic system—the brain's reward center. The altering of the limbic system is particularly important since this part of the brain controls and regulates our ability to feel pleasure.

The brain is a communications center consisting of billions of neurons. Networks of neurons pass messages back and forth among different structures within the brain, the spinal cord, and nerves in the rest of the body. These nerve networks coordinate and regulate everything we feel, think, and do. Each nerve cell in the brain sends and receives messages in the form of electrical and chemical signals. Once a cell receives and processes a message, it sends it on to other neurons. Messages are carried between neurons by chemicals called neurotransmitters. Neurotransmitters attach to a specialized site on the receiving neuron called a receptor. To send a message, a brain cell, or neuron, releases a neurotransmitter which is carried to the receiving brain cell. This causes changes in the receiving cell and the message is delivered.

Drugs affect the brain by tapping into its communication system and interfering with the way neurons normally send, receive, and process information. Some drugs, like marijuana and heroin, can activate neurons because their chemical structure mimics that of a natural neurotransmitter. The similarity of structure fools receptors and allows the drug to attach and activate the neurons. Since this is not the brain's natural process, it leads to abnormal messages being transmitted through the network.

Other drugs, like methamphetamine or cocaine, cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals. This disruption produces a greatly amplified message and disrupts communication channels.

Most drugs of abuse in some way target the brain's reward system by flooding it with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and feelings of pleasure. This is our brain's reward system. Over-stimulating this system with drugs, however, produces euphoric

---

46. Whether or not addiction is a "disease" is a debated topic. This paper will treat addiction as a disease—not for the purpose of excusing the sin that an addict struggles with, but rather, in order to shed light on the insidious and destructive nature of addiction. The addicts brain structure and operation have been changed by drugs. It is therefore feasible to consider addiction a disease as it acts like a disease.

effects which strongly reinforce the behavior of drug use—encouraging the user to repeat their drug use.

Our brains are wired to ensure that we repeat life sustaining activities by associating those activities with pleasure and reward. When this reward circuit is activated, the brain knows that something important has happened that needs to be remembered, and teaches us to do it again and again without thinking. Since drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.

Some drugs can release 2 to 10 times the amount of dopamine that natural rewards do. In some cases, this can occur almost immediately, (as when drugs are smoked or injected), and the effects can last much longer than those produced by natural rewards. The resulting effects on the brain's pleasure circuit dwarf those produced by naturally rewarding behaviors. Due to such a powerful reward people can be easily motivated to take drugs again and again.

Over time the brain adjusts to the presence of overwhelming surges and dopamine by producing less dopamine or by reducing the number of receptors that can receive signals. Dopamine's impact on the reward circuit of the brain of someone who abuses drugs can become abnormally low and that person's ability to experience pleasure is reduced. This is one of the reasons why individuals who abuse drugs eventually see life to be dull and are unable to enjoy things that were previously pleasurable. Now that person must keep taking drugs again and again to try and bring their dopamine back to normal levels. This only makes the problem worse. It is a vicious cycle. The person will need to take larger amounts of the drug to produce the familiar dopamine high. This effect is known as tolerance.

The same sort of mechanisms involved in the development of tolerance can eventually lead to prevent changes in neurons and brain circuits. Long-term drug abuse can trip and trigger adaptations of habit or nonconscious memory systems. Conditioning is an example of this: cues and a person's daily routine or environment become associated with the drug experience and can trigger uncontrollable cravings whenever the person is exposed to these cues, even if the drug itself is not available. This conditioned reflex is extremely durable and can affect a person, causing them to desire drugs even after many years of abstinence. Drug addiction erodes a person's self-control and ability to make sound decisions while producing intense impulses to take drugs.<sup>47</sup>

In summary, when abused, drugs can fundamentally alter the brain's structure and functions. The brain of an addict is structurally different than a healthy brain. When left to function on its own, the brain of an addict will generally not allow the addict to say no to his drug of choice. Due to the depletion of the brain's chemicals, and the onset of withdrawal symptoms, the altered brain

---

47. National Institute on Drug Abuse, "Drugs and the Brain," *Drugs, Brains, and Behavior: The Science of Addiction*, July 2014, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain>.

feels that it needs to be restored to normal and drives the addict with cravings to return to his drug in order to achieve this.

The understanding of addiction that we have today is a blessing. It helps us see addiction for the disease that it is—not a moral failing or lack of self-control. That being said, there is most certainly a spiritual component to addiction. Neither the spiritual nor the scientific insights about addiction should be dismissed. It is important that each is handled and presented carefully.

### **The Spiritual Component of Addiction**

The Bible makes it clear that drunkenness is a sin. Scripture does not explicitly speak of drugs, but one can rightly assume that if allowing the chemical of alcohol to have control over your mind and actions is a sin, then allowing any chemical to have control over you is a sin. Reason would stand that the addict is guilty of sinning day in and day out—every time they use a chemical to get high. How can the addict *not* be a moral failure? It is damaging and counterproductive to call addicts moral failures because of the manifestation of their sin—that is—repeatedly turning to their addiction. For Christians, addiction is a disease that Satan uses to try and pull them away from Christ. The addicts' sin does not make them any more of a moral failure than the next human who may not struggle with addiction to substance, but does struggle with other sins. Humankind's true moral failure is seen in its sinful nature. All humans, when born, are entirely and utterly sinful. They are entirely separated from God. Humankind is born into a state of "moral failure" of the most severe kind—also known as, original sin. From the moment of birth, all of humankind is deserving of hell—not even because of what they have done—simply because of who they are. All sins that humans commit are a result of this ultimate moral failure.

We do not call Christians moral failures when they fall into sin. We say of the Christian who struggles with gossip: “They are a sinner/saint who struggles with the sin of gossip.” We say of the Christian who struggles with anger: “They are a sinner/saint who struggles with the sin of anger.” We say of the Christian who is on the road to addiction: “They are a sinner/saint who struggles with the sin of overindulging.” And finally, we say of the Christian who is an addict, “They are a sinner/saint who struggles with the sin of insobriety.” It is truly important to keep in mind that of all the sinner/saints in the church, some of those who need the most help are those that struggle with addiction because their brains have been rewired and it is extremely rare that they are able to help themselves.

Addiction is very much a spiritual matter. It is a disease that Satan uses with the intent of (1) keeping *unbelievers* distanced from God or (2) pulling *believers* away from God. True Lutheran theology has something important to offer those who struggle with addiction and those who are in recovery. Of all of Christianity, true Lutheranism maintains the unaltered doctrines of Scripture—doctrines that run parallel to helping us understand the spiritual component of addiction. We will take some time to evaluate some of the uniquely Lutheran doctrines that help us better understand addiction.

The doctrine of original sin shows us that we cannot, by our own thinking or choosing, come to God in any way. Our own efforts to earn salvation are futile. Our own efforts to cease sinning are useless. We are wholly and entirely sinful enemies of God. We are powerless over sin—it owns us. The parallels between the Lutheran understanding of original sin and how addiction manifests itself are striking. The first step of Narcotics Anonymous<sup>48</sup> (NA) states, “We admitted that we were powerless over our addiction; that our lives had become unmanageable.”

---

48. As I speak about Alcoholics Anonymous (AA), NA, and other 12 step programs in this section, I am neither advocating it nor condemning it. An evaluation of 12 step programs will be saved for later in the paper.



In a spiritual sense, this is all of humankind—all of our minds are hopelessly warped. The Christian addict in recovery is in a unique position to understand the depth and depravity of sin and the destruction it can cause.

To draw another parallel between Lutheran doctrine and addiction: Just as salvation comes from outside ourselves by the work of the Trinity, the addict needs outside help. Rarely does an individual recover from addiction on his or her own—for they are powerless to do so. Even as one browses internet blogs and finds testimonials from those who maintain sobriety “on their own,” it often becomes clear in their testimonial that they did not, in fact, do it entirely alone. There is often some incident or “rock bottom” that causes them to evaluate their lives—something that shakes them badly enough that they begin to realize something is not right. They then research and learn more about addiction. They learn more about what is going on in their life and brain. They receive help retraining their brain from some outside source—even if they do not receive therapy or are not involved in a group like Narcotics Anonymous. Help for the addict comes from outside himself.

To help fight against the “moral failure” label our society has given addicts, it would be helpful to refrain from calling addiction a sin. The sin associated with addiction is the sin of insobriety. Whether the addict’s sin of insobriety is a voluntary or involuntary sin is less clear. In most cases, when someone initially chooses to overindulge in alcohol—or use drugs to get high—this might be considered voluntary sin. However, when the average person repeatedly chooses to overindulge or get high, at some point, the line between voluntary and involuntary sin begins to blur. As previously stated, drugs and alcohol can change the brain. As the disease of addiction progresses and changes the brain, the action of continuing to use becomes less and less

of a choice—it becomes less and less voluntary—and becomes an uncontrollable impulse or reflex.

Satan will use any sin—voluntary or involuntary—to try and separate God from his children. Just because a believer is stuck in addiction, does not mean they are separated from God. A distinction should be made between the sinful actions of an addict and persistent sin that leads to the hardening of the heart. Can a believer's fall into addiction destroy faith? Yes, it can—all sin has the power to destroy faith. Has the faith of every believer who falls into addiction been destroyed? By no means. Is the believer who fell into addiction and overdosed in hell? By no means. The only unforgivable sin that condemns is unbelief. Therefore, as with most pastoral theology topics, this is a case by case matter and by no means black and white. It is a matter of the heart. When the disease of addiction has taken over the brain, it does not mean that faith has been destroyed.

When seeking to help addicts, and the family members of addicts, it is important that we are careful with how we present the spiritual component of addiction. If we do not completely rid our minds of the “addiction is moral failure” mentality then we heap unnecessary shame on the addict; and the addict already struggles with shame. Owen Flanagan speaks of the shame of addiction:

The non-addict will get that the addict might fail if a drink or drug is right in front of her (we relate from chocolate candy type experiences). But the addict will decide, indeed she will resolve not to purchase alcohol or cocaine and then find herself driving to the liquor store or crack house. This is shameful and is experienced as such both on the way to score, although in something of a blur, and afterward. I am ashamed of who I am, not simply for what I did. And it builds. An addict is someone, who like everyone else, has educational, career, and inter-personal aspirations, and he reliably fails to achieve them; or he achieves them to some degree, and then his addiction undermines these accomplishments. Every alcoholic and every addict in rooms of AA and NA and most every memoir of addiction (even if the author is not inculcated into 12-step ways of speaking) will speak of extreme feelings of shame for who one is, who one has become in

one's own eyes, even if one has not yet been fully seen by others and even if objective failures are still in the "not-yet" category.<sup>49</sup>

It can be said that the addict—and especially the addict who recognizes they are caught in the struggle of addiction—sees themselves as a moral failure. When their view of themselves as a moral failure is confirmed by others, it only serves to drive them further into addiction.

Numerous steps in the available 12 step programs focus on dealing with negative self-talk and negative self-beliefs, as these are detrimental and lead to relapse. Steps 4, 8, 9, and 10<sup>50</sup> of Narcotics Anonymous focus on naming the things that bring shame to the addict and addressing them. They take inventory of who they are so they can confront it rather than run from it. They take inventory of the ways they have wronged themselves and others. They do what they can to make amends for their wrongs. And they rigorously and repeatedly continue to take a "moral inventory" so that the things that cause them shame do not pile up and drive them back to using. Steps 5, 6, and 7<sup>51</sup> help the addict bring their wrongs and shortcomings to God—as they understand him—so that they might be absolved and receive from him strength to overcome their shortcomings.

A large portion of the 12 step process is built on helping the addict identify and dissolve their guilt and shame. Nothing absolves guilt and shame better than the unadulterated doctrines of Scripture. The Lutheran understanding of sin and grace is in a position to help addicts in a

---

49. Flanagan, Owen, "The Shame of Addiction," *Frontiers in Psychiatry* 4 (2013), 7, <http://journal.frontiersin.org/article/10.3389/fpsy.2013.00120/abstract>.

50. Step 4: We made a searching and fearless moral inventory of ourselves.

Step 8: We made a list of all persons we had harmed, and became willing to make amends to them all.

Step 9: We made direct amends to such people wherever possible, except when to do so would injure them or others.

Step 10: We continued to take personal inventory and when we were wrong promptly admitted it.

51. Step 5: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

Step 6: We were entirely ready to have God remove all these defects of character.

Step 7: We humbly asked Him to remove our shortcomings.

unique and powerful way. The addict is no more of a “moral failure” than anyone else in the human race. We were moral failures long before we fell into our sins of weakness and sins of choice. We were moral failures from the moment we were conceived. All of humankind are complete moral failures through and through. It is not possible to be more of a moral failure than when we are conceived. The unbelieving newborn baby is entirely separated from God because of his sinful nature just as the unbelieving mass murderer or serial killer is entirely separated from God because of his sinful nature. Addicts are no different from the rest of humankind in this sense—they are no more of a moral failure. Like all of humankind, addicts need to know the truths of grace and forgiveness. Their sins have been forgiven—sins of past, present and future. Their failures have been forgiven—failures of past, present, and future. Sins of getting high, sins of abusing substance, and sins of hurting other people are all forgiven in Christ. The Christians’ guilt is no more since they are a new creation in Christ. Christ takes away guilt and brings freedom from shame. This is most certainly the message that the addict needs to hear. There is unconditional forgiveness in the work of Christ.

## CHAPTER IV - TREATING ADDICTION

This chapter will look at the options that are available for addicts. For those personally faced with addiction, those attempting to help equip someone else to deal with addiction, and those attempting to advise the family members of an addict, this will be the most helpful chapter. If you or someone you love is confronted with addiction you should consult medical professionals. In addition, I recommend reading *Clean: Overcoming Addiction and Ending America's Greatest Tragedy* by David Sheff. Although his book is written from a non-Christian perspective, it gives an accurate and realistic depiction of addiction and can help individuals think through this complicated illness and the options that are available to treat it.

### **The Fractured State of Addiction Treatment**

Unfortunately, the odds are stacked against the addict. This is either in part—or largely—due to the fractured state of addiction treatment available. Addiction treatment in the United States is in disarray. David Sheff speaks about our failed treatment efforts. He notes the intimidating and often times conflicting smorgasbord of voices that cry out to the addict as the silver bullet to recovery:

Prevention efforts have failed, and so too has what passes for a treatment system. Ninety percent of people who need help never receive it. Indeed, people with addiction are more likely to wind up in prison than in rehab. Those who do get treatment enter a broken system that's almost impossible to navigate...The fortunate ones consult specialists, but even then, reliable professionals are difficult to identify, and they often offer contradictory advice...

Often the more information people get, the more bewildered they become. Parents or spouses of addicts are sometimes told that they must kick their loved ones out of the house. Some say that nothing short of letting an addict hit bottom will help, even though hitting bottom can mean dying. Some people recommend Outward Bound. Others push wilderness programs that are similar to Outward Bound...

Of course, many people recommend rehab, but what *is* rehab, exactly? There's no standard definition; it's a generic word for a wide variety of treatments, including some that are outrageous... Some rehabs are run by self-anointed "experts" with no training or credentials, unless you count their own recoveries... In many states, anyone can open a rehab...

People in need become disillusioned, skeptical of every claim, and distrustful of every promise, because most available addiction treatments are a haphazard collection of cobbled-together recovery programs...

Many rehabs are for-profit businesses—it's a multibillion-dollar industry. For profit doesn't necessarily equate with poor treatment, but for addiction-treatment programs, as for other health-care institutions, the bottom line can influence staffing decisions; highly trained physicians and therapists are expensive. Also, the bottom line may cause a rehab to admit patients who aren't appropriate for it. Some rehabs are mills, churning patients through. Some charge tens of thousands of dollars a month... Given the free-for-all environment, the lack of regulation, the lack of accepted treatment protocols, and some individuals' greed and willingness to exploit the desperately ill and their families, it's no wonder treatment statistics are so disheartening. A majority of patients who enter treatment never complete it.<sup>52</sup>

Cynical though he may sound, David Sheff is right. Addiction—be it to alcohol, opioids, or methamphetamine—is a nationwide problem that we are largely failing at treating. When it comes to treating addiction, there is no silver bullet. No matter what the treatment option, when one looks at the estimated success rates, it can be disheartening. The medical—and recovery—community is vehemently divided on what the best path of treatment for addicts. The bottom line is that each addict must be treated individually.

In spite of the dismal state of addiction treatment in America, there is hope for the addict. There are many addicts who live lives of successful recovery. To start, simply knowing that the state of America's addiction treatment is in bad shape can help. There are numerous treatment options that do more harm than good. How can someone personally dealing with addiction—or trying help a loved one deal with addiction—possibly hope to make the right decision? Are we left to luck alone? Time, research, and calculated action can help to overcome and avoid some of the problems previously mentioned regarding the fractured state of professional help and medical

---

52. *Clean*, Sheff: 15-17.

opinion. Unfortunately, when faced with addiction, time for research and planning may not be an available luxury. Therefore, being educated on the available treatment options *before* being faced with addiction can save lives.

A reasonable comparison for addiction is cancer. When it comes to light that a patient has cancer, a long process has just begun. What type of cancer is it? How severe is it? What are the treatment options? Can it be easily treated or will a long grueling battle ensue? It may be in remission now, but will it come back five years from now? It would be foolish for someone facing cancer to not get a second opinion—maybe even a third and fourth opinion. The cancer patient works with a team of medical professionals to map out a plan for treatment. Sometimes the plan works. Sometimes the plan must be adjusted. If one treatment is not working, a new plan is devised. Sometimes a variety of treatments are needed to get the job done. There is no “one-size-fits-all” treatment for the disease of cancer. Think of the disease of addiction in a similar way. There is no “one-size-fits-all” approach for treating addiction. Treating addiction is not an exact science.

### **Interventions**

In the ideal situation, the addict would go into treatment willingly. This gives addicts the greatest chance of success because it means they recognize a change is needed their lives and they are willing to attempt recovery. Already from this initial step of treating addiction, it is obvious there is not a “one-size-fits-all” solution. Interventions can be placed into two categories: formal and informal. Of the two, informal interventions are preferred, but by no means guaranteed to work.

### Informal Interventions

While begging or threatening an adult addict will sometimes get them to enter treatment, it does not always. The less confrontational—informal—approach can be more effective. The conversation (or conversations) about the addict's actions and need for treatment might happen with family, friends, bosses, pastors, or coworkers. In some cases time is more of a factor than others. If someone is using heroin and fentanyl, time is not on your side. The chance of overdose and death is ever-increasing with their continued use. In such cases, an informal intervention may not be the best approach. If someone is abusing Vicodin, alcohol, or marijuana, then depending on their use habits, the chance of death is not as grave and there will likely be time for an informal conversation to take place. You should not wait for your loved one to “hit bottom,” as in many cases, this could mean death.

For parents whose children are still under the age of 18, it is legal to force their children into treatment. Again, the goal is for the addict to go into treatment willingly, but when this is not happening, a parent should use their legal sway to get children into recovery. Violence and aggression should be avoided.

### Formal Interventions

The prototype for a formal intervention is well-known in society. Family and friends of the loved one are seated around the room and the addict is (usually unknowingly) brought in and addressed by those present. Emotions are high. Pre-written letters from the loved ones of the addict to the addict may be read. Formal interventions are extremely difficult to navigate and should, if possible, be done with the help of a professional. To give the greatest chance of success, a professional interventionist or therapist trained in such matters should be present as a referee. A



pastor, while potentially a good option for an informal intervention, should not be the first choice to lead a formal intervention. If its beneficial for the addict, pastor should be present with friends and family.

The biggest challenge that faces the formal intervention is keeping emotions as neutral-positive as possible. That is to say, the intervention should not be characterized by anger, blame, threats, or chastisement as these things can easily lead to the addict becoming angry, defensive, and obstinate; it may result in the addict fleeing. The intervention needs to be characterized by expressions of love, care, concern, hope, empathy, and support. A professional interventionist or therapist can serve as a neutral referee to help keep a productive atmosphere for the intervention.

### **Detox**

Even this early step of addiction treatment comes with potentially life-or-death decisions.

Although it is not always the case, withdrawal can be life-threatening. Withdrawal from alcohol and benzodiazepines can be fatal. Withdrawal from opiates is rarely fatal. However, withdrawal is often times miserable enough to drive the addict to return to using. The severity of withdrawal is dependent on what drugs were in the body, for how long, and in what quantity. We will take a look at the most common forms of detox. Of those available, medical detox is the best option.

#### **Self-Detox (“Toughing It Out”)**

Often times addicts—whether of their own volition or at the encouragement of others—will try to go through detox on their own. This is one of the least effective treatment options available.

Not only does it rarely work, it can also be dangerous. As the addict tries to detox on his own, his body and mind begin to work against him. His brain screams out for more drugs to help balance

out the sudden absence of dopamine. Even if he manages to fend off the urge to return to his drug of choice, he ends up self-medicating with another drug like marijuana or alcohol. In addition, withdrawal symptoms can drive him back to drug use.

### Cold Turkey Detox

To quit something “cold turkey” means to quit it and everything else immediately. The rationale behind this method of detox might be that if addicts want to remain clean, they need to feel the pain of their body detoxifying itself—if they have that horrible memory, they might think twice before using again. This method is outdated—the first known medical encouragement of this method comes from 1809. This method can also be dangerous. As previously mentioned, depending on the situation, withdrawal symptoms can be fatal. It is still advocated by some addiction experts and is the only option offered in some programs. Often times, the addict is driven to return to using because of the discomfort of withdrawal symptoms in this method.

### Medical Detox

This form of detox is done under the care of medical professionals. It is not focused on giving the addict a horrid memory that will scare him and hopefully keep him from wanting to do drugs ever again; rather, medical detox is focused on safely removing the toxic chemicals that are in the addict’s body. An initial examination should be done to determine if detox is actually needed. It is largely dependent on what type of drugs were used, for how long, and in what quantity. Depending on drug type, duration, quantity, and history an addict may arrive to detox extremely malnourished, anemic, dehydrated or suffering from other illnesses.

Some rehabilitation programs reject this form of rehab since it requires medication. While the risk of switching from one addiction to another always exists, most of the drugs that are used in medical detox are non-addictive. However, any addictive drugs used in this process are used in moderation and under medical supervision. Trained doctors should be administering the medications with the goal of tapering use as the body readjusts to life without drugs. The medications used will, again, depend on the various drug use details of the person undergoing detox.

### Rapid Detox

Proponents of rapid detox claim it can help get people drug free faster—sometimes in a matter of hours. Patients are usually given an anesthetic and a mix of medications. This mix includes a number of drugs that are used to treat withdrawal symptoms and the opiate blocker naltrexone. It is sometimes promoted as the “detox of the future.” However, many suggest avoiding this method of detox due to it being high risk and having a number of dangerous side-effects.

Generally, experts agree on three pieces of advice when it comes to detox: “Toughing it out and cold turkey should be rejected in favor of medical detox. Decisions about detox should be made with the advice of professionals. Medical detox must be administered and supervised by doctors who have been trained in the procedure.”<sup>53</sup>

### Primary Treatment

This is certainly the most dizzying and fractured area of addiction treatment. The options available for post-detox treatment are endless. Some are beneficial. Some are harmful. For our

---

53. *Clean*, Sheff, 144.

purposes we will place the available treatments into two categories, which differ in their level of treatment: inpatient and outpatient. We will consider some things to look for and some things to avoid. Again, treating addiction might be likened to treating cancer in some ways. What treatment plan works for one addict may not work for another. Medical evaluation from a professional can help to determine if inpatient or outpatient will best serve an addict. For more specifics on what to do and what to look for when selecting a treatment facility and path, see Appendix 1.

### Inpatient Treatment

Inpatient treatment, or residential treatment, is a form of treatment in which addicts live in the rehabilitation center or hospital from which they are receiving treatment. Although inpatient and outpatient treatments often offer at least some of the same therapies, these therapies differ in duration and frequency. Inpatient treatment is far more intensive. Participants attend multiple sessions and therapies throughout the day. At the risk of oversimplifying who should receive inpatient treatment: the more progressed the disease of addiction is, the more likely a person will need inpatient treatment. In addition, those who struggle with both addiction and also a moderate to severe psychiatric disorder should consider inpatient treatment. Family members should use any means possible to get suicidal or violent patients into inpatient treatment. A trained professional at an Alcohol and Other Drug Abuse (AODA) treatment program will be able to conduct an initial assessment and make a recommendation about what level of care is best for an addict based upon established guidelines.

Inpatient treatment has a number of benefits. Inpatient treatment keeps addicts out of their old environment. Often times, if addicts return to their old environment immediately after

detox, they will relapse. Any number of triggers, cues, pressures, or stressors from their old environment can increase the likelihood that they use again. In inpatient treatment, they are removed from these factors and given structure that can help them realize life can be lived without drugs. Inpatient programs that are staffed with qualified people provide a safe and controlled environment in which patients can be monitored. They generally do not have access to drugs.

Inpatient treatment also has a number of drawbacks—some of which are largely dependent on the particular inpatient facility. Inpatient treatment is often expensive and insurance companies are rarely willing to pay for more than 28 days of treatment—sometimes less than that. Some addicts refuse to go to inpatient treatment because it upends their lives. And finally, inpatient facilities are not always reliable—they are not always staffed with qualified people who regularly spend time with the patients. Inpatient facilities that are run solely by people whose “credentials” merely include the “school of hard knocks” (i.e. they have their own history of drug use and recovery) should be avoided. Facilities that use “tough-love,” or “my way or the highway” approaches to recovery should also be avoided.

### Outpatient Treatment

Outpatient treatment can be very similar to inpatient treatment yet it is far less intensive. Rather than having individual and group therapies multiple times a day, outpatient treatments typically consist of one session a day, several times a week. Outpatient treatment allows individuals to continue with their lives—they do not have to leave jobs and families to complete a 30-90+ day treatment. A downside is that the addict may not be removed from his or her toxic environment—although they attend treatment during the day, they return home at night. As with

inpatient treatment, when searching for counselors and therapists for outpatient treatment, one should be careful to select qualified individuals who specialize in the field of addiction.

## CHAPTER V – OTHER CONSIDERATIONS

This final chapter will look at some miscellaneous considerations about addiction and opioid addiction. 12-step programs for treating addiction are widespread. The most well-known 12 step programs include Alcoholics Anonymous, Narcotics Anonymous, and Celebrate Recovery. These programs are typically not considered treatment programs. Rather, they are considered supportive as they support sober living. Since they are not considered treatment programs, they will be discussed in this chapter. In addition, there will be an overview of Resilient Recovery by Jason Jonker who is a member of the Wisconsin Evangelical Lutheran Synod. The chapter will conclude with a section on preventing opioid addiction.

### **An Evaluation of 12-Step Programs**

12-step programs have served to help many addicts maintain sobriety. Some of their strengths include: community/group therapy, cognitive-behavioral therapy (CBT), anonymity, and various types of motivation.

12-step programs tend to have an emphasis on group therapy. Many people find this to be a positive experience as they are able to relate and learn from the experience of others. When properly moderated, group therapy can be quite productive.

12-step programs typically have CBT built into them. CBT is psychotherapy directed toward solving current problems by teaching skills to modify dysfunctional thinking and behavior. The most obvious example of CBT would be the steps themselves.

Anonymity is another strength, as it tends to be a draw for many people. For someone to enter recovery and admit they need help can be a difficult thing. The promise of anonymity can help to ease fears of being judged and privacy concerns.

And finally, many programs have built in motivations that can be positive. For example, members of AA receive “chips” based on how long they have been sober—these are tangible mini-trophies of sobriety that can be worked towards.

Some potential drawbacks of 12-step programs include: anonymity, inadvertent blame, a forced religious component, and unintentional demotivation.

Some will point out that the “anonymous” aspect of AA has caused some unintended harm. Should those who battle addiction feel the need to remain “anonymous”? It may be easy to get the impression that recovery and addiction is something that should only be talked about at meetings and with those who attend meetings. Would it not be more productive for our society if it was in a sense “desensitized” to addiction? Those struggling with addiction are not far-off, no-name people who go to meetings in the dark of night to avoid being seen. They are our neighbors, our family, our friends, even we ourselves. Addiction has become more and more common—it would be helpful to bring light to the problem rather than make people think they need to be cloaked in anonymity.

12-step programs can cast inadvertent blame. Within 12-step programs, those who relapse can be brushed off with oversimplified mantras like, “They were not working the program.” The implication is that a person fails because they do not work hard enough on the steps or attend meetings frequently enough. Another example of this inadvertent blame would be the AA greeting: “Hi I’m (insert name), and I’m an alcoholic.” This causes an addict to primarily



(maybe only) identify as an addict. Are they an addict? Yes, but from a Christian perspective it is important we realize our identity is found in our new person, not in our old person.

12-step programs tend to have a forced religious component. Since the primary audience of this paper is likely to be a small handful of pastors in the Wisconsin Evangelical Lutheran Synod, this paragraph will touch on a dilemma that readers find themselves in as they help those recovering from addiction. From a non-Christian perspective, 12-step programs are frustrating because they have religion woven in to their every fiber. From a conservative Lutheran Christian perspective, 12-step programs can be frustrating because they have false doctrine woven deep into their programs. No 12-step program is ideal in regard to doctrinal content. All are full of errors. For a conservative Lutheran, Celebrate Recovery will be most difficult to deal with as their meetings and materials are very worship-oriented. AA and NA, although they have religious components woven throughout their materials, do not require participants to ascribe to any particular set of beliefs and the meetings are less worship-oriented. It should also be noted, that while it is easy to pick apart the doctrinal errors of 12-step programs, whether or not a member or a loved one (or we ourselves) should be in one of these groups is not black and white. For many addicts, these groups can be a lifeline. Addiction can be a matter of life and death. Addiction is a very personal matter and the road to recovery is unique to each individual. If an addict is working a 12-step program and maintaining sobriety, I would caution against attacking the program and discouraging their attendance.

Finally, some of the same things that were intended to be motivators in 12-step programs can end up causing demotivation. For example, if an addict who had maintained sobriety for 5 years relapses, he might feel little motivation to start again. His 5-year “chip” stares him in the face as a reminder of all he lost.

### **Resilient Recovery**

The pastor looking for doctrinally sound recovery resources should purchase a copy of *Resilient Recovery*<sup>54</sup> by Jason Jonker. These materials are a set of Bible Studies meant to be done in groups with all who are wanting to work on recovery—whether it be from a substance or from a harmful habit.

### **Preventing Opioid Addiction**

Rarely do we think in terms of *preventing* opioid addiction, but we should. Preventing is simple, and can save lives. It involves: mindful handling of prescription medications and alternative pain treatments.

Patients would be well-served to be tastefully wary of the pain medications that doctors prescribe them. When a doctor prescribes a pain medication, make sure to ask him if there is a less potent medication that he thinks would be sufficient for pain treatment. When you *are* on pain medication, make sure to follow the instructions from the doctor. In addition, do not leave half used bottles of pills in your medicine cabinet. Curious adolescents may take and abuse prescription drugs that can be found. For many young people, addiction begins in their parents' medicine cabinets. Dispose of unused pills. You can search online to see how to dispose of prescriptions properly, or search to find out the date of the next “National Prescription Drug Take Back Day.”

Finally, consider using alternative pain treatments if at all possible. There are numerous theories on pain management and a number of remedies. Some more well-known ones include,

---

54. Jonker, Jason C., *Resilient Recovery: A Law and Gospel Approach to Experiencing the Grace of God in the Midst of Recovery* (CreateSpace Independent Publishing Platform, 2016).

acupuncture, chiropractic treatment, yoga, biofeedback, aromatherapy, relaxation, herbal remedies, massage, and cannabidiol (CBD) oil. In addition, if you are against medicinal marijuana, it might be worthwhile to rethink that position. While marijuana certainly has negative effects, it has been proven to be effective for pain treatment and is a far safer than the painkillers that are currently commonplace.

## CONCLUSION

Being caught in the grips of addiction or having a loved one who is caught in the grips of addiction is a frightening, frustrating, and dangerous place to be. There is hope. There are treatment options. Addiction does not exclude one from the reach and power of Christ. The pastor plays an important role in treating the spiritual component of addiction. However, it is important that he realize that fighting addiction is a battle with many fronts. He should encourage those struggling with addiction to also seek the help and opinion of a medical professional. This paper in no way intends to be an authoritative source for information on addiction and addiction treatment; it merely hopes to be a starting point for those who are faced with addiction in one way or another. When faced with addiction, reliable medical attention should be sought.

## APPENDIX 1. CONSIDERATIONS WHEN DISCUSSING TREATMENT OPTIONS WITH A DOCTOR<sup>55</sup>

- [Treatment] should be evidence-based. SAMHSA has online and National Registry of evidence-based programs and practices. This is different from the SAMHSA listing of rehabs...
- A physical exam by a physician should be routine. Patient should be monitored frequently by an M.D. and RNs while they're in the program. It's still possible for them to have seizures or other life-threatening events during rehab.
- Patient should be screened or rescreened for co-occurring psychiatric disorders by a psychiatrist or psychologist trying to identify patients with dual diagnosis. Patients with co-occurring problems, eating disorders, attention disorders, and mood disorders must be in programs that treat them as well as their addictions.
- Program should continually evaluate patients and adjust treatment as needed, and if a program identifies a patient who requires treatments beyond or outside the program's expertise, it should work with the patient and their family to identify appropriate care and should coordinate a seamless and safe transition into a new program. Patients should never be discharged without a solid plan in place.
- Therapists and counselors should have degrees in counseling, clinical psychology, social work, or other similar relevant specialties. Therapist's or counselor's former addiction is not a qualification by itself. As Walter Link, professor of Psychiatry and director of integrated substance abuse programs at UCLA, said ruefully of some programs, "the more of a drug addict you were, the more of an expert you become." Having cancer doesn't enable you to treat cancer. Also, programs should have adequate numbers of those professionals so patients can meet with them regularly. Bonding with the therapist can be a critical part of treatment, so patients should meet frequently with one primary therapist.
- There should be a team approach to treatment. This applies to inpatient as well as outpatient treatment. As needed, MDs, therapists, registered nurses, and counselors should consult with one another about an individual patient. As needed, they should also consult with other specialists.
- All support staff working with patients should be well trained and closely supervised.
- Teenagers should be treated in programs designed specifically for them. Many programs throw adult and adolescent addicts together, and some counselors believe that teenagers should learn from older addicts who have suffered addictions that began when they themselves were teenagers. The experts I polled disagree. If they're in treatment with the adults, some kids will be intimidated and less able to participate and benefit from therapy. In addition, some treatments developed for adults backfire when they're used with kids.

---

55. *Clean*, David Sheff, 159-161.

And kids can dismiss the idea that they're addicted when they compare themselves to older addicts; further, they might want to emulate older hardcore addicts who's used more drugs and more varieties of drugs.

- Ideally, patients should enter programs good for them, depending on their race, religion, sexual orientation, or culture. Some addicts should be treated in single-sex programs.
- Program shouldn't offer one-size-fits-all treatment. They should be able to tailor the treatments they offer to meet individual needs.
- One qualified person, a case manager, or primary therapist, for example should work with each patient coordinator and oversee his treatment, monitor progress, and be sure he gets the specific help he needs.
- Programs should evaluate whether it would be beneficial for family members to be involved in treatment.
- Program staff should be capable of identifying patients who require care that the program can't provide. In such cases, they should help patients find appropriate care and help with the transition to the new program.

## BIBLIOGRAPHY

- American Society of Interventional Pain Physicians. “The American Society of Interventional Pain Physicians (ASIPP) Fact Sheet,” 2012.  
<http://www.asipp.org/documents/ASIPPFactSheet101111.pdf>.
- Compton, Wilson M., Jones, Christopher M., and Baldwin, Grant T. “Relationship between Nonmedical Prescription-Opioid Use and Heroin Use.” Edited by Longo, Dan L. *New England Journal of Medicine* 374.2 (2016): 154–63.  
<http://www.nejm.org/doi/10.1056/NEJMra1508490>.
- Diversion Control Division. *2018 Aggregate Production Quota History for Selected Substances*. U.S. Department of Justice - Drug Enforcement Administration, November 15, 2017.  
[https://www.deadiversion.usdoj.gov/quotas/quota\\_history.pdf](https://www.deadiversion.usdoj.gov/quotas/quota_history.pdf).
- Firth, Jamie, Kirzinger, Ashley, and Brodie, Mollyann. “Kaiser Health Tracking Poll: April 2016 - Substance Abuse and Mental Health.” *The Henry J. Kaiser Family Foundation*, April 2016.  
<https://www.kff.org/report-section/kaiser-health-tracking-poll-april-2016-substance-abuse-and-mental-health/>.
- Flanagan, Owen. “The Shame of Addiction.” *Frontiers in Psychiatry* 4 (2013).  
<http://journal.frontiersin.org/article/10.3389/fpsyt.2013.00120/abstract>.
- Harriet, Ryan, Girion, Lisa, and Glover, Scott. “‘You Want a Description of Hell?’ OxyContin’s 12-Hour Problem.” *Static.Latimes.Com*, n.d. <http://www.latimes.com/projects/oxycontin-part1/>.
- “How Science Has Revolutionized the Understanding of Drug Addiction.” *Drugs, Brains, and Behavior: The Science of Addiction*, July 2014.  
<https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.
- International Narcotics Control Board. *Narcotic Drugs: Estimated World Requirements for 2017, Statistics for 2015*. New York: United Nations, 2016.
- John Temple Books, “American Pain,” n.d. <http://johntemplebooks.com/books/american-pain/>.
- Jonker, Jason C. *Resilient Recovery: A Law and Gospel Approach to Experiencing the Grace of God in the Midst of Recovery*. CreateSpace Independent Publishing Platform, 2016.
- Keefe, Patrick Radden. “The Family That Built an Empire of Pain.” *The New Yorker*, 30 October 2017. <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>.

Kuhn, Cynthia; Swartzwelder, Scott; and Wilson, Wilkie. *Buzzed: The Straight Facts About the Most Used and Abused Drugs from Alcohol to Ecstasy*. 4th ed. New York, NY: W. W. Norton & Company, 2014.

Marcovitz, Hal. *The Opioid Epidemic*. San Diego, CA: ReferencePoint Press, Inc, 2018.

Muhuri, Pradip K.; Gfroerer, Joseph C.; and Davies, M. Christine. *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*. Center for Behavioral Health Statistics and Quality - Substance Abuse and Mental Health Services Administration, August 2013.

National Institute on Drug Abuse. "Drugs and the Brain." *Drugs, Brains, and Behavior: The Science of Addiction*, July 2014. <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain>.

National Safety Council. "99% of Doctors Prescribe Highly-Addictive Opioids Longer than CDC Recommends," 24 March 2016. <http://www.nsc.org/Connect/NSCNewsReleases/Lists/Posts/Post.aspx?ID=108>.

Peterson-Withorn, Chase. "Fortune of Family Behind OxyContin Drops Amid Declining Prescriptions." *Forbes*, n.d. <https://www.forbes.com/sites/chasewithorn/2016/06/29/fortune-of-family-behind-oxycotin-drops-amid-declining-prescriptions/>.

Portenoy, Russell K.; and Foley, Kathleen M. "Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases." *PAIN* 25.2 (1986): 171. [http://journals.lww.com/pain/Abstract/1986/05000/Chronic\\_use\\_of\\_opioid\\_analgesics\\_in\\_n\\_malignant.4.aspx](http://journals.lww.com/pain/Abstract/1986/05000/Chronic_use_of_opioid_analgesics_in_n_malignant.4.aspx).

*Prescription Drug Abuse*. Publication. Research Report Series. U.S. Department of Health and Human Services - National Institutes of Health, October 2011.

"Prescription Opioid Use Is a Risk Factor for Heroin Use," January 2018. <https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use>.

Psychology Today. "Addiction," n.d. <https://www.psychologytoday.com/basics/addiction>.

Regier, Paul. "Drug Epidemics: Now and Then." *Addiction Unscripted*, 4 April 2016. <https://addictionunscripted.com/drug-epidemics-now-and-then/>.

Rosenthal, Elisabeth. "Patients in Pain Find Relief, Not Addiction, in Narcotics." *The New York Times*, 28 March 1993. <http://www.nytimes.com/1993/03/28/us/patients-in-pain-find-relief-not-addiction-in-narcotics.html>.



Samuels, Alana. "Are Pharmaceutical Companies to Blame for the Opioid Epidemic?" *The Atlantic*, 2 June 2017. <https://www.theatlantic.com/business/archive/2017/06/lawsuit-pharmaceutical-companies-opioids/529020/>.

Sheff, David. *Clean: Overcoming Addiction and Ending America's Greatest Tragedy*. Boston, MA: Houghton Mifflin Company, 2013.

Teater, Don. "Prescriber Attitudes and Behavior Related to Prescription Opioid Pain Medication" presented at the National Safety Council – Opioid Prescriber Media Briefing, 2016.

Temple, John. *American Pain: How a Young Felon and His Ring of Doctors Unleashed America's Deadliest Drug Epidemic*. Guilford, CT: Rowman & Littlefield, 2015.

United States General Accounting Office. *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*. Report to Congressional Requesters, December 2003.