ADDICTION SUMMIT

12 Steps & Keys to Recovery
Guest: Dr. Marvin Sepalla

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Dr. Thomas: Well, welcome to another edition of The Addiction Summit. And today, we get to speak with a very good friend of mine, Dr. Marv Sepalla. Welcome!

Dr. Sepalla: Glad to be here.

Dr. Thomas: So, Marv Sepalla, you are the chief medical officer of Hazelden Betty Ford. But you're also a good friend. For those of you who don't know my story, my wife had major jaw surgeries, ended up on multiple rounds of heavy dose opiates. And he really helped guide her through that journey of getting off of opiates after surgeries. But you also pioneered the way for my journey into the addiction treatment world.

But I want to hear about your journey. Tell us, how did you get involved with addiction medicine?

Dr. Sepalla: Yeah, it's a long story.

Dr. Thomas: I think we want to hear it.

Dr. Sepalla: I went to treatment after dropping out of high school at 17. And I grew up in a small town in Southern Minnesota, Stewartville. And I started drinking at 12 and then smoking pot. And by 15, using one drug or another,

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or alcohol every day pretty much. At 17, dropped out of high school. And at that point, my folks realized it really was a big problem. And so, all of a sudden, they brought me up to Hazelden, where I work now, actually.

Dr. Thomas: Wow! Full circle.

Dr. Sepalla: Yeah. So in Center City, Minnesota, in the original farmhouse that they bought in 1949, is where I went to treatment. The newer buildings were around it. But I was in this old farmhouse, which was really, really neat, too. It was like just being in someone's house.

Dr. Thomas: So you were in treatment at age--

Dr. Sepalla: Seventeen.

Dr. Thomas: 17. You got sober at age 17?

Dr. Sepalla: Nope.

Dr. Thomas: No.

Dr. Sepalla: Just had treatment at 17. And they got me back into high school. It's amazing, but that also was being around a lot of people that were using. And they told me, in treatment, to stay away from the people that are using and try and hang out with people who weren't. People who weren't wanted nothing to do with me. I was just an outcast that way.

And so I got lonely really quick. And then, it was real natural to hang out with my old friends. And so I lasted five days, actually. And I went to a concert in the Twin Cities. And was trying to tell these two friends how I wasn't supposed to be using drugs or alcohol anymore the whole way until we got there. And then, I was using drugs and alcohol.

Dr. Thomas: You were back at it.

Dr. Sepalla: Yeah, just like them.

Dr. Thomas: Okay, okay. So how did you finally conquer the addiction thing?

Dr. Sepalla: About shortly after that, I had left a few different jobs. I'd get a check and just disappear. And my folks had disowned me. And I was living out of my car around Rochester, Minnesota going from friend to friend and

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needed a job again because I never quit a job. I just wouldn't go back. I didn't quit it. I just didn't go back. I just disappeared, I guess. And so I needed a job.

The two major employers in Rochester are IBM and Mayo Clinic. And my dad worked at IBM. So I had just assumed they would never hire me. And so I applied at Mayo. And I applied to be a janitor because that's all I thought they would ever hire me for. And I lied and said that I had graduated from high school. And so they sent me away. They didn't have a job.

But two weeks later, they called my mother because I had to give some phone number and address. So I gave my parents'. And she got ahold of my girlfriend, who got a hold of me. And I went in for an interview. And they sent me over to the cardiovascular research lab where I was hired as a lab technician, which I didn't even know such jobs existed.

Dr. Thomas: Right. So a high-school dropout lab technician.

Dr. Sepalla: Yeah, yeah. But the next day I went to HR. And told them that I actually had missed a lot of school and hadn't graduated yet because I was afraid they'd get my transcript and find out, and I'll be fired anyways. So I might as well just tell them. And they didn't bat an eye. They just said, "Well, you've got the job. So get your diploma."

And my teachers had agreed to let me come to their homes during the summer to see them and get all that done. But I didn't. Because I was using, I just blew it off and didn't do that. But the offer was still there. So after getting the job and getting started in the lab, which I was working under two-world famous physicians, actually, or researchers, one physician, one PhD, the PhD had helped invent the heart/lung machine. He was actually a veterinarian. And did a lot of animal research. And it was an animal surgical lab.

And the other guy was president of the American Heart Association at the time. And he was on the Board of Governors and Board of Trustees at Mayo. Never saw him out of a three-piece suit. And the other guy, the veterinarian, I never saw him in a tie, let alone a coat and tie. He was this really eccentric, brilliant guy that lived out in the woods with athletic tape around his shoes.

Dr. Thomas: Oh, my, goodness.

Dr. Sepalla: So in that lab, Fellows came from all over the world to work under these two guys. And so there were people from Belgium, and Germany, and Sweden, England, Australia, Brazil. And they kept asking me what I was

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going to do with my life because I was assisting them and their experiments. Mostly assisting the surgery and stuff.

And I never told them about my addiction because I assumed they'd just fire me because we were dealing with all kinds of drugs in the lab/a surgical lab. And I'm the one that had to draw them up, and put them in solution, and everything. And it wasn't--

Dr. Thomas: So were you still partaking of the stuff you were drawing up at this point?

Dr. Sepalla: Early on, I was. Yeah. And then, I stopped.

Dr. Thomas: How did you stop, though? That's hard to do.

Dr. Sepalla: So I finally got to a 12-step meeting. I didn't go back to treatment. They had told me in treatment I should do that. That that was about the only thing available. There was absolutely nothing available for a 17-year-old when I left treatment, except go on a 12-step meeting. There were no adolescent treatment programs. There was no counseling of any kind at the Mayo Clinic or anywhere else nearby.

And I didn't go. I relapsed. And now, just the deterioration was really rapid with that kind of access in the lab. And so I just got really desperate and went to a 12-step meeting in Rochester, Minnesota. And there were three guys there. They were all over 70. And I was 18 at the time.

And they just welcomed me. I don't know what they said. I don't remember at all. But whatever they said got me to go back. And I felt accepted and validated there. And the meeting grew. And other people came. But those three guys actually died within six months of my arrival. So they saved my life and disappeared, basically.

Dr. Thomas: Wow! That must have been hard for you?

Dr. Sepalla: Well, you'd think so. But I was so self-centered, I didn't even really notice. I hate to even say that. But it was like I was so caught up in myself and trying to just get by and stay sober that it didn't even occur to me that that might be a problem. But what happened was I missed a meeting. Back then, in Rochester, people went to one meeting a week, that was it.

Dr. Thomas: That was it.

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Dr. Sepalla: And so that's what I did. I went to one meeting a week. So every Sunday morning, I went to that meeting that I started out in. And I was doing so well. I was doing better than I ever had in my life. I felt so good that I thought, "I should just skip a meeting. I don't need to go every week." So I missed one on a Sunday. And on Monday, I was doing cocaine. Just like that, yeah.

Dr. Thomas: Wow! Back at it.

Dr. Sepalla: Yeah. And I called a guy I was meaning to ask to be my sponsor because I hadn't done anything. I was going to meetings. But I didn't talk at the meetings. I didn't read anything. I didn't work the steps. I did nothing except show up once a week. And so I called this guy and said I needed to talk. And he said, "Well, come on down to my office."

And, of course, I just lied that I can't get there right now. And finished my day at work. I could've left. There wasn't anything going on. I just wanted to do a whole lot more cocaine before I went. So I lied to him. And so I got together with him. And I was absolutely convinced, at this point, that I was one of those people that was never going to get sober because I'd tried treatment.

It wasn't my idea. My parents just dropped me off one day. But I actually argued against it for a couple of weeks. And then really recognized that I do have this just like everybody else there. And then, on my own, when I first got that job at Mayo, I lasted two weeks just because I got this great job. And that didn't work either. And now, I'd gone to meetings for six months. And that didn't work either. And I told John that. I said, "You know, I don't think I can get sober. The AA doesn't work, either.

Dr. Thomas: So there is this controversy about 12-step programs. And they just don't work for everybody. What do you say to that?

Dr. Sepalla: I'd say I agree with that statement. They don't work for everybody. And there's been a lot of research that has proven the efficacy of 12-step meetings, especially of AA, because that's really what's primarily been studied.

And John Kelly, a Harvard psychiatrist addiction guy is right now, I think, finalizing a Cochrane review on AA and all the research that has been done on it to describe just that efficacy of AA and just how well it does and how well it may not work for some folks. But mostly, that it is an effective way of

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addressing abstinence long term. It's not like a treatment program. It's like a relapse prevention program in my mind.

And so he's pulling all that together. And I don't know when it's coming out. It may have already come out. I know it's real soon. And that research is really solid, but it's not well known. In fact, he's repeating a Cochrane review because somebody else did one several years ago. And their interpretation of the literature was the opposite that AA didn't work very well.

Dr. Thomas: It didn't work very well.

Dr. Sepalla: And it's based on a skewed look at the literature, actually.

Dr. Thomas: It worked for you, though, right, eventually?

Dr. Sepalla: Yeah, oh, yeah. Yeah, so I've been sober since that day that I did the cocaine and talked with my first sponsor.

Dr. Thomas: And you were 18 or 19?

Dr. Sepalla: Nineteen.

Dr. Thomas: Nineteen years old.

Dr. Sepalla: Yep.

Dr. Thomas: This guy looks like a teenager. But I know you're about…Well, we can't say age here. But you can probably get some discounts as a senior citizen.

Dr. Sepalla: Yeah, I can.

Dr. Thomas: That's a lot of sobriety, folks. I think one of the things I'd be interested in your thoughts on is a lot of our viewers, if you're struggling with an addiction and you don't where to turn, what thoughts might you share with the viewers about where can people go?

Dr. Sepalla: There's a lot of options. When they've surveyed people that have addictions, what they found out is most people go to 12-step meetings because that's the number one people do more so than treatment even. And those programs are available almost everywhere in the United States, big cities, small towns, and the likes. And they're free, basically. They ask you to

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donate a dollar or two at the end. And you don't have to so that they're accessible. They're free. They're effective. So if you don't have the money, it's a good way to go.

Treatment program, themselves exists all over the country. You can go to the Substance Abuse Mental Health Services Administration, SAMHSA, website and get information about all these different treatment programs all over the country and the information associated with them.

If you just go on the Web and type in addiction treatment, you're going to get these phone banks that are complete scams for these really expensive for-profit treatment places. And probably won't get good treatment, honestly. And they'll say that they're going to line up your specific characteristics and your experience of addiction with the right program for you. But it's always the one that bought them out.

Dr. Thomas: That gave them the referral fee.

Dr. Sepalla: Exactly. So not a good system, unfortunately.

Dr. Thomas: Yeah, I've actually looked online. And viewers, if you've done that, you've seen that there's a lot of advertised, paid options. "Call this number. And we'll help you." I know the organization that you're with is a non-profit. Hazelden Betty Ford is the largest non-profit, I believe, in the United States.

Dr. Sepalla: It is, yeah, for addiction treatment.

Dr. Thomas: Yeah, my wife went to Hazelden there in Oregon. And it saved her life. So there are bumper stickers that say, "Addiction Treatment Saves Lives." It's very true. But I like that you pointed out that 12-step programs are free. And they're accessible. And anybody can walk into one of those rooms. And if you don't like the first meeting you go to, just go to another one, right--

Dr. Sepalla: Oh, yeah.

Dr. Thomas: because meetings have different flavors.

Dr. Sepalla: They do. And it's hard to go to 12-step meetings because, first of all, it suggests that you're going to go against your very nature and stop using drugs and alcohol. It's driving the individual to keep using. It's completely

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unnatural to stop. So it's hard to get there for that reason. It's also hard to walk into a room full of strangers.

Dr. Thomas: Absolutely.

Dr. Sepalla: And just admit you've got this huge problem that you haven't admitted to anybody, basically. And then they talk about spirituality. There's all kinds of inside, baseball-type language that they have. And it's just really strange at first. And so, like you said, you got to go to different meetings until you find one that you fit in and you enjoy and you feel like you're a part of. And, as a doc, you shouldn't go to the bikers' meeting.

Dr. Thomas: No. That's good advice.

Dr. Sepalla: And as a biker, you probably shouldn't go to the doctor's meeting. But you can.

Dr. Thomas: I am a doctor and I ride bikes. And I can go to both!

Dr. Sepalla: That's right.

Dr. Thomas: So, folks, I go to 12-step meetings. And actually, that's how I got sober. So I was getting desperate. And I was too embarrassed to go to treatment. So I was the opposite. So I slid into a 12-step meeting. But I knew I needed help. And I was so grateful that they were there.

Dr. Sepalla: Ah, and it's so common for people to walk in. Like I said, it is the number one thing people do. And yeah, people still just walk in. Have never had treatment. And they stay sober. Just your own experience. It's incredible.

Dr. Thomas: Yeah. Not everybody stays sober right away.

Dr. Sepalla: No, not at all.

Dr. Thomas: But you can just keep going back. And so yeah, I'm a real proponent for 12-step programs. And I know Hazelden supports that, as well, don't they, the Hazelden Betty Ford program?

Dr. Sepalla: Yeah.

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Dr. Thomas: You've got someone in treatment. They've had time to be detoxed. Tell our viewers a little bit about the process. When somebody goes into treatment, what happens?

Dr. Sepalla: Okay. So we were founded in 1949 at a time when Madison, as a whole, wanted nothing to do with addiction treatment. And partially because they couldn't get paid but, also, because they didn't see it as a disease. So why would anyone in Madison do much about addiction?

So in our program, it started out using the 12 steps because back in the late 40s, early 50s, there wasn't anything that was considered effective for the treatment of addiction. And they started hearing about these people in AA that were staying sober, which was miraculous, basically. And you had to be desperate, really desperate to go to AA back then because it was just this fledgling whole organization. And at first, you had to admit you had this problem, which was totally stigmatized. And go--

Dr. Thomas: Nobody wants to admit they have a problem.

Dr. Sepalla: No, man! But it worked. And so our founders realized that it worked. And that's how they based the initial treatment. But shortly after opening, they hired a psychologist, Danny Anderson who really put Hazelden on the map by bringing psychological treatments. Bringing a real organized examination of addiction treatment. And starting to study addiction treatment and the outcomes to be sure that what was being done actually did work, instead of just counting on what people thought worked.

And so some of the things we do are still based on what we started with because we still find the 12 steps really effective. And the literature supports that it's an evidence-based practice as described by the federal government. But we, also, as Danny Anderson brought, we used behavioral therapies. We used motivational enhancement therapies.

We used contingency contracting and other evidence-based practices. Contingency contracting is an easy thing to describe in that, let's say you're a doc and you're addicted and the state board says you've got to go to treatment. Well, that's a contingency because they also say if you don't, you won't be able to practice in Madison.

Dr. Thomas: Yeah, your license is gone.

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Dr. Sepalla: So the contract is if you go to treatment and stay sober, you get your license. You get to practice. That's a pretty good contingency and very motivating.

Dr. Thomas: Very effective.

Dr. Sepalla: Yeah, yeah.

Dr. Thomas: How about for the non-doctor who's not being threatened by a medical board. What kind of contingency things [crosstalk 20:42].

Dr. Sepalla: So that can be family issues. A spouse says, "Hey, if you don't go to treatment, it may be it. Our marriage may be over." Or your boss says, "If you don't go take care of this, you're losing your job."

Dr. Thomas: Okay. And so then the treatment program just supports that process.

Dr. Sepalla: It does. And we also use other types of contingencies like in our outpatient settings, we've used a pizza party contingency, basically. If everybody shows up for group today—so let's say there's 13 people. And they all show up—the next group will supply pizza. Well, the pressure's on then for everybody in the group to get everybody else to show up.

Dr. Thomas: To get there.

Dr. Sepalla: Yeah, so it's a neat contingency because it's a positive one.

Dr. Thomas: That's interesting.

Dr. Sepalla: And even simple things like a teeny little gift bag of the funniest little things can actually work for people to get them to an appointment to get that.

Dr. Thomas: Be motivating. I think a lot of folks who struggle with addiction might be aware that there are other health issues, whether it be anxiety, and depression, schizophrenia, bipolar, being suicidal. In addiction medicine, I think we talk about dual diagnosis, that term. And maybe you can inform our listeners about the importance of addressing that whole patient, the whole picture.

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Dr. Sepalla: It's really necessary. So when people arrive, we do a full evaluation: medical evaluation with a history and physical examination. We do a psychological evaluation trying to determine if there is psychiatric illness. Usually, they've already told us both some medical history and their psychiatric history. And in our adult settings and in our adult residential settings, over 75% of people show up with a diagnosis of a psychiatric illness before they even came to treatment.

Dr. Thomas: What are you finding the most common?

Dr. Sepalla: Depression, anxiety, and PTSD just by a long shot. Yeah.

Dr. Thomas: Yeah. If you're struggling with depression, anxiety, PTSD, or if you have abuse issues in your past, a treatment center may well be the place to start, right, because you can be in a safe environment? And you're getting all your issues addressed.
Dr. Sepalla: It's true. And the thing is, the vast majority of our patients have insurance. And use it to come to treatment, like over 90%. And insurance won't pay for residential treatment unless you've got some other problem, basically.

Dr. Thomas: Oh, really?

Dr. Sepalla: Yeah, it's like you got to have either really, really severe addiction that's off the chart severe, or standard addiction with a psychiatric addiction, or standard addiction with a major medical illness. And the addiction's undermining your ability to actually address the other or vice versa.

And so being in a setting like a residential facility allows us to evaluate all of that. Figure out a really good plan. Put that plan together. And you're out of your element. You're insulated from the drug and alcohol use so that you can actually be sober. And during that period better evaluation and treatment can take place. And you can get your feet on the ground again. And then, follow up long term in an outpatient.

Dr. Thomas: Right. So tell our viewers, perhaps, what do you do? You've got a loved one. They're in trouble. But they don't want to do anything about it. What does the family do?

Dr. Sepalla: So that's really common. People usually don't want to address this illness. And, in fact, the number one reason people don't go to treatment is they don't even recognize they have this problem. And 85% to 95% of people

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with addiction, don't know they have it. And so when you hear these statistics about treatment access, it fails to tell you that 85 to 90 aren't even seeking access. It's just this 10% to 15% group that is actually looking for help.

But the family often recognizes the issues before the individual. And when they do, there's a number of things one can do. But I often recommend if people just call me up and say, "What should we do?" I'll tell them, "Well, let's just arrange an appointment to see an addiction specialist, a single appointment. And see if you can convince the family member to go in for that appointment.

And you can say, "We think you may have a problem. We don't know. Something's going on. We're really concerned. We love you. Why don't you just have an appointment and get this figured out? And then, we'll go from there. We're not asking you to go to treatment. We're not asking for any commitment, except one appointment." See an expert. If you had cancer, we'd go to an expert.

Dr. Thomas: Go to an expert. So what about those tough cases where they've got a really bad problem, but they are not willing to address it?

Dr. Sepalla: So in those cases, there's a couple of different ways of going about that. Interventions are often used where you bring in an expert to do them and a bunch of other family members. And you confront the individual about what's going on and often already have a treatment bed ready, and waiting, and all that. And that can be an effective way of getting someone in the door. And it brings the family together.

And often a good interventionist is going to really teach the whole family about this illness and give them tools and means of addressing themselves longer term so that, even if the individual with the problem doesn't go in, or just goes in, and then leaves, they can start to heal. And their healing will actually help drive the individual in a positive direction, too. But a lot of people don't want to do that either. And so under those circumstances--

Dr. Thomas: The families don't want to do an intervention, right?

Dr. Sepalla: Yeah, yeah, it's hard to do.

Dr. Thomas: It's hard to do.

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Dr. Sepalla: And it depends on who it is. And there could be a history of abuse. All kinds of things that get in the way. And so there's something called a CRAFT Model that's been shown to be effective for families in that situation. And it basically uses a kind of behavioral therapy approach to understanding change for the family members, not the identified person with addiction.

And the family members can start taking care of themselves and talking to the individual with addiction a lot differently than they have because usually it's a crisis that comes up. Everybody's angry. And it's chaotic. And no one knows what to do.

But in this model, the family all starts taking care of each other or just the spouse, or whatever and treating that individual differently. But with an expectation that's different, as well. "That I'm not going to put up with this anymore. The whatever the chaos and everything else is. And I'm moving down this path of healing. And if you want to, that'd really be nice."

And it's an evidence-based program that over time has really been shown to be effective, too.

Dr. Thomas: Do they offer that at Hazelden Betty Ford?

Dr. Sepalla: We offer some of that training at a couple of sites so that families can get that. And just go about it on their own. And some psychotherapists know that, as well.

Dr. Thomas: The model?

Dr. Sepalla: Yeah.

Dr. Thomas: I know there's Al-Anon, which is a branch of 12-step programs for the family of. And that's a program that will start to teach the family member how to set appropriate boundaries and work on their own issues. And actually, I'm in a 12-step program. And I find so much personal value in being involved in that journey of personal growth. It's incredible. And I will often feel sorry for the poor people who aren't addicts or alcoholics because where do they go?

Dr. Sepalla: Exactly.

Dr. Thomas: But there is Al-Anon.

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Dr. Sepalla: There is. And it's really powerful for those family members. And it's great support. And they can learn a lot from other people that have gone through it already and figure out ways to take care of themselves in the midst of addiction in the household.

Dr. Thomas: Change is difficult, right?

Dr. Sepalla: It sure is.

Dr. Thomas: And when you have addiction tangled in with the depression, anxiety, and PTSD, and all that, it's difficult. So we need support. And it's just not something you do in isolation.

Dr. Sepalla: No! And I always think of addiction as a disease of isolation. It's isolating for the individual with it. The family's isolated because they don't want to admit that this is going on. Usually, no one understands it unless they happen to have had some other family member with an addiction. And so people facing it are absolutely confused. They're confounded. They don't know what to do. And they don't want to admit to it. And that's a bad place to figure something out. It never works well.

Dr. Thomas: Right. I've heard it said, "Your secrets keep you sick."

Dr. Sepalla: That's right. Yeah.

Dr. Thomas: Yeah. What are some of the things that you would say are evidence-base, cutting-edge, exciting directions that we're going in addiction medicine are you personally aware of?

Dr. Sepalla: Because of this opioid crisis, we've really altered how we provide treatment for those with opioid use disorders and opioid addiction. And we've combined the use of a couple of medications: buprenorphine and naltrexone for the treatment of opioid use disorders. In addition to altering how our treatment goes, we have, in general, people with all kinds of different addictions grouped together during group therapy.

But when we had to change that our folks with opioid use disorders actually got together, and that became more powerful for them. They don't do it exclusively. They still get together with folks with other addictions, as well. But that really helped improve our treatment outcomes by having them talk with each other and do some group therapy together. The medications have helped a great deal.

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We've got some six-month data that we just now have submitted to publication that shows really good outcomes from this in a number of ways. One, over 90% are completing residential treatment, which is up from 25. We had 25% of people leaving early. Now, it's about, from a residential treatment--

Dr. Thomas: A residential treatment for opioids?

Dr. Sepalla: Yeah, just your opioid use disorders and now a drop to about 6%-8%.

Dr. Thomas: Wow! Over 90% of your patients who come in for opioid use disorder are completing.

Dr. Sepalla: Yeah, they're completing residential. We want them to transfer to outpatient for long-term care. And 75% are doing so in our system. And there's some percent that go to some other system, too. So we're able to keep people involved. Keeping people engaged is absolutely essential for good outcomes.

Dr. Thomas: Explain to our viewers, perhaps, how medication assistance is helping these patients. And what exactly does that look like?

Dr. Sepalla: So I think initially what it looks like is engaging people and helping them to stay off the opioids. And in our setting, off of alcohol and other drugs, too. But the medicines are specific for opioids. And as long as people can stop and reduce their craving, they've got a chance to continue in treatment and stay sober long enough that they start feeling a lot better. Their brain starts healing. And it becomes a little more natural to get into recovery, than to go back to use.

Dr. Thomas: Right. So I know you're familiar with my clinic. It's just a small clinic outpatient detox. We take mostly opioid addicts. It used to be OxyContin. And now it's heroin. Almost all of our patients ended up on heroin because it's so cheap and available. And that full opioid is just so powerful that when you don't have it, the withdrawal is just unbearable. And the relapse is just constant.

And so we're using buprenorphine. I think you use that, as well. It's one of the Hazelden programs, Hazelden Betty Ford programs. Maybe you can explain. Are you having success getting people all the way off of buprenorphine? How quickly? Is there a shift in philosophy about that?

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Dr. Sepalla: We start people on buprenorphine expecting them to stay on it for months, if not a couple of years. And a lot don't. There's a really quick dropout rate. All the studies show that people stop buprenorphine rapidly and usually about half or more do.

Dr. Thomas: Are they relapsing when they stop it?

Dr. Sepalla: Usually, yeah, almost always, yeah, unfortunately. And it's really fairly quick. I always think of it as in a weak moment, "I decided I'd better change, right. So I take buprenorphine. And then, I just want to go get high again,"and do so.

But in our setting, we're using the buprenorphine in a similar way. We assume some people will stay on it longer than 18 months to a couple of years. We just don't have a literature that provides evidence of who needs to stay on it long term and who doesn't.

Dr. Thomas: Yeah, that is the tricky part.

Dr. Sepalla: It is.

Dr. Thomas: I'd be interested in your take on the Harm Reduction Model of treating opioid addiction, for example. And I'll take a stab at it. But then, you can correct me, here. So the thinking is, in the addiction world, is if I give you enough methadone or buprenorphine—so keep you on a high dose—you won't go out and use because your opioid receptors are full. And what are your thoughts about that?

Dr. Sepalla: I think in theory it's absolutely correct. But when you look at the high dropout rate early on, that it isn't totally true, because if it was as simple as that description, then if we gave people buprenorphine, they would all stop using opioids. But half or more stop buprenorphine and go back to opioids right away. And methadone, I haven't seen similar data. And I haven't looked at that for a while. But I suspect it's almost identical.

Dr. Thomas: Similar. Yeah, the methadone clinics, the patients who end up in my clinic having been in a methadone clinic, they're not happy with that. Having to go in every day to get a dose. They're like shackled to the clinic. It's hard to keep a job. And those clinics are keeping these folks on such high doses that I don't think they feel good. You might get high for a while. It's so long acting.

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For the viewers who aren't familiar with buprenorphine and how it works, it's a partial agonist and a partial antagonist. So you're getting some opioid effect. You're also blocking the opioid receptors. And people don't usually get high from buprenorphine. Unless you've never used opioids, of course--

Dr. Sepalla: Yeah, then you do.

Dr. Thomas: it can be dangerous. But if you've been using a lot of heroin, you're not going to get that high feeling. And I think that's what you're describing. People, they want to get high. The ones who drop out. And I deal in my clinic with mostly the younger patients, 30 and under. And a lot of this age group, they're not ready to be done getting high. Yeah.

But I have found—I wonder if your experience has been similar—when I first started doing this work about 8/9 years ago, I was trying to help people get off of it quickly. So I was doing a rapid taper. You start at 16 milligrams. And within 3 to 6 months, you're done. And everybody was relapsing. So now, I go a lot slower and where there's a lot of talk with the patients making sure that…And I'm having some really good success with people keeping their jobs. They're staying in school. As we very slowly, wean them off.

Dr. Sepalla: Good deal.

Dr. Thomas: But it's still really hard at the end. Have you experienced that problem--

Dr. Sepalla: Oh, yeah, it's really hard to get [crosstalk 38:00].

Dr. Thomas: when you get down to the low doses to get completely off?

Dr. Sepalla: Yeah, it's terrible that way. And I think, the way I understand it, and it's probably not the whole story, but it's so tightly bound to the receptors—buprenorphine is tightly bound to the receptors in our brain, those opioid receptors—that even when you get down to low doses, it's still having a major effect.

Dr. Thomas: A major effect.

Dr. Sepalla: And then, suddenly you go below the level--

Dr. Thomas: And they feel it.

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Dr. Sepalla: yeah, it's a big deal change all of a sudden. And it reminds people, it triggers just fear and anxiety associated with severe opioid withdrawal because it is opioid withdrawal. Only it's mild usually, but still, it triggers all these other concerns. And the scientists, the researchers in addiction call it a Motivational Withdrawal Syndrome. And it motivates continued use because you don't want to withdraw. You don't want to feel that way.

Dr. Thomas: Right, withdrawal from opiates is very, very powerful and intense.

Dr. Sepalla: Yep.

Dr. Thomas: Yeah. Do you have any tips for how to make that--?

Dr. Sepalla: How to get people off that?

Dr. Thomas: Yeah because honestly, in my clinic, that's the biggest challenge. We get down to about one, two, three, four milligrams. And that final step off is where we're having the biggest trouble.

Dr. Sepalla: We used to use tramadol, which is a very weak opioid agonist. And it allowed for a transition of a type that really helped people to avoid some of that withdrawal from the buprenorphine.

But the DHEA scheduled it differently. They put it as Schedule II. And as a result, you can't use it for withdrawal purposes, which is really unfortunate. And I'm hoping ACM's going to address that and ask them to change that so we could use that again because it was helpful.

I know people use tiny, tiny doses of buprenorphine. Like go to specialty pharmacies and get really, really low dose to taper even more. But when I've tried that in the past, it wasn't that effective. I think it's one of the few things that actually helps a bit. But it's not going to do the whole thing.

You're using clonidine, which used to be used alone for opioid withdrawal. And there's a couple of other similar medications. One that I believe is going to be coming on to the market that's really similar, has a little bit less likelihood of some of the side effects that clonidine, that at least would help limit some of those withdrawal symptoms.

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But the other thing I know is a whole lot of support from their peers is…And I'll tell you a story. I met a nurse in one of our programs. And she had taken buprenorphine for an opioid use disorder for eight months and after eight months, decided she was going to stop.

But she wanted to stay sober. She was really involved in AA. She was still going to outpatient treatment. And when she decided to taper her buprenorphine, all her peers just hung around with her all day long, every day. And they were calling her at night and making sure she was okay.

Dr. Thomas: Not alone.

Dr. Sepalla: Yeah. And she said that it made it so easy. And I think it's not necessarily going to be easy for everybody under that circumstance. But it certainly puts you in a position or the likelihood of relapse is so much less. And some of those withdrawal symptoms aren't going to be witnessed in the same manner if you've got a whole bunch of people around that are there cheering for you and helping you move forward.

Dr. Thomas: Right. Well, prior to buprenorphine, what did we do? It was cold turkey, right?

Dr. Sepalla: Yeah, use a little of clonidine. And cover up the problem.

Dr. Thomas: Yeah, a little clonidine, some anxiety things. And, folks, if you've gone through acute withdrawal it's horrible. But it only lasts a few days, the most intense physical withdrawal from opiates. But then, the patients are just left anxious. Just clinging on with no energy. And that can last a while. And that's where that support that you were talking about to just keep you safe for a while—weeks, maybe months.

Dr. Sepalla: Yep, it's—

Dr. Thomas: And so plugging in with a network if you can get into a 12-step program. If you can have a huge support network, that thing of disease of isolation, as you mentioned, you just don't want to isolate.

Dr. Sepalla: No that's a really dangerous one.

Dr. Thomas: You're probably familiar with the Rat Park studies or the rat studies where, if they're in isolation, they'll take cocaine, or alcohol, or opiates. But in a community, they can ignore that stuff.

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Dr. Sepalla: Part of the current and new understanding of the neurobiology of addiction suggests that early use and social use, people who don't have addiction, is all about positive reinforcement. And positive reinforcement, "I like it. I'm going to do it again." It's like, "I like chocolate. I'm going to eat some more."

And with addiction, that can start the whole process because people usually do like intoxicants, especially those of us that are genetically prone to addiction. And yet, once addiction really takes hold, it turns into negative reinforcement. And negative reinforcement is the relief of a negative stimuli.

Dr. Thomas: Right, the withdrawal.

Dr. Sepalla: Yeah, partially the withdrawal, but also, there's all this other stuff going on in the brain. Partially, psychologically, the consequences of a life of addiction, the person just disliking themselves, ashamed, feeling guilty about all these things. But also, the whole stress system in our body is responding to the intoxication by trying to keep the individual up, and walking, and talking.

And so stress is usually a bad thing. And our stress system, and if it's fight or flight, we need it. It's like you got to have that energy to get out of there or to fight. Whatever? But that whole system is engaged constantly during the course of addiction. So not for just a brief period of excitement. It's there. And it stays on.

And then it gets pinned. And by pinned, I mean it just gets stuck in the on setting. And then, we stop using. And it stays like that for a long time. And it's basically, the experience is a combination of depressed, anxiety angst. And as a result, early recovery is not a real good feeling most of the time. And especially if a person just runs out of whatever they're using for a couple of days, they're in withdrawal. And they got this going on. So they feel awful.

Dr. Thomas: That angst.

Dr. Sepalla: Yeah. And then, if you stop for a longer period, this still goes on, and hangs on, and hangs on, but finally starts to improve. And so the medications, for opioid use disorders, help to prevent that, especially buprenorphine, but also naltrexone to limit that negative reinforcement stuff. So it takes care of it so the individual isn't feeling so bad.

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All that involvement with other people and everything helps, too. So there's a lot of things that can address that. But I always look at it as that's probably the main reason for relapse is that lasts a long time. And then, in early recovery, there's a lot of bad things you've got to deal with that are the results of your use.

Maybe you're broke. Maybe you lost your job. Maybe your primary relationship has kicked you out. You're done. Or you've ruined your car. And nothing's working right. There's all this stuff that piles up. And that psychologically feels just like the stress system stuff.

Dr. Thomas: Overwhelming.

Dr. Sepalla: Yeah, this whole, it's a negative affective state. And it drives you back to use because that's the answer.

Dr. Thomas: Yeah, you just don't want to deal with it.

Dr. Sepalla: And you don't even have to think about it. It's just subconscious driving an individual to what works to eliminate that pain, that angst. And so I always think of it, as well as, like if you're sober 5, 10, 50 years, and your best friend, your spouse dies, whatever, and all of a sudden you're back there in that same awful feeling. It's not depressive illness. It's that same depression, anxiety associated with a specific event. But it feels the same that that subconscious drive for addiction just is going to kick back in.

And for people that are weary and aware of that and have been putting in their time doing really good things with their life, and in recovery, and all that, it's not going to trip them up. But for other people that may be at risk for one reason or another—like let's say that spouse dies. And they've got all kinds of other stress in their life at that point for some reason—that could be just enough to allow for addiction.

Dr. Thomas: Throw you back into addiction.

Dr. Sepalla: Yeah, absolutely. And it really makes sense to me, especially with opioid use disorder. When I ask people about how they're feeling, they always feel rotten when they're not using. It's terrible.

Dr. Thomas: Well, opioids are a huge, powerful boost of pain relief, endorphins, dopamine. You've given a talk, "My Dopamine Made Me Do it." Aren't most of the addiction somehow propping up dopamine?

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Dr. Sepalla: They sure are, more so than any natural re-enforcer. And it's in the reward center of the brain where it's all about survival. What keeps us alive? Food, nutrition, sex for the survival of the species. And human reaction also releases dopamine. All those things, those natural re-enforcers, release way less dopamine than the drugs of abuse.

Dr. Thomas: So when you take these drugs of abuse, you get this huge flood of dopamine. And it's such an empowering feeling, people want to chase that again.

Dr. Sepalla: Oh, yeah, yeah.

Dr. Thomas: But then, they're dopamine depleted. You've used it all up. And you have to keep hammering to try to get that feeling. When you remove that powerful drug, if it's an opioid or alcohol or meth or whatever, they're crashing. And it's just a hopelessness, desperation feeling. And they just keep chasing that.

Dr. Sepalla: They do. And that downregulation of dopamine, that lowered level of dopamine, because of regular use of whatever substance, in addition to requiring more and more of the drug to get the same effect—and people just seeking, especially with the opioids, more and more powerful opioids to get that effect again—they don't have the same reinforcement or reward from those things they used to enjoy doing or the things in their life that really are meaningful. All that becomes secondary because their dopamine isn't getting the burst it used to get from that. So it's like life is dull.

Dr. Thomas: It's everything else is dull.

Dr. Sepalla: Except when I use.

Dr. Thomas: I remember when I was in my drinking days and drinking too much. Sitting here chatting with you would have been dull.

Dr. Sepalla: Oh, sure, yeah.

Dr. Thomas: Now, I'm having a kick just talking to you. That's the kind of silly things, though. You can be in relationship with people or you can have dinner with your family and have joy in that. But not when you're in your addiction.

Dr. Sepalla: No.

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Dr. Thomas: No, that there's just not enough of a dopamine boost there.

Dr. Sepalla: One of my favorite example of that is a woman who came to see me in the private practice. And she was a methamphetamine addict. And she had tried to stay sober, had an apartment, single mother, two kids under five. And she went off to the grocery store for food for the kids.

And she saw her methamphetamine dealer. And she went on her own. She disappeared for four days. Kids are back in the apartment. And the kids were taken away by DHS. Thank, God, they were reported. And the kids were taken care of by somebody because she was gone four full days.

She came to me after being sober for maybe almost two years wanting to get her kids back. So they'd been taken away a long time. And she loved her kids as much as I love mine. And yet, in that moment when she saw her dealer, getting high was way more important than getting those groceries and getting back to those kids. And in that moment, she didn't have a choice. She was triggered and she was using.

Now, it's weird because when I look at addiction, some mothers would've gone and got the groceries, gone back home, sent the kids off to the ex-husband, and then went and saw the dealer. Some people would have that control. And others don't. And there's all these different aspects of addiction we don't fully understand like why couldn't she make that decision in that moment?

And it just reveals the power of this disease over us. And yet, the importance of using that drug compared to the survival of her own children, the love for her own children was less important in that moment. And yet, while I talked to her, absolutely clear cut that she loves those children and always cared for them when she could.

Dr. Thomas: So, folks, if you're struggling with addiction, I think that kind of a story just highlights the importance of, "Get help."

Dr. Sepalla: Yeah, absolutely.

Dr. Thomas: There are places to go like treatment centers, like 12-step programs, like addiction counselors, addiction doctors. Marv, if you were going to tell folks what you think they really need to know, what would be some of your best advice?

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Dr. Sepalla: Man, I guess the top one is that this is a disease. It's a chronic disease of the brain. It's not an ethical or moral problem. It causes ethical and moral problems of behaviors we do. It gets a lot of attention.

Dr. Thomas: You mean I'm not just a weak person?

Dr. Sepalla: Yeah, exactly, you're not a weak person.

Dr. Thomas: But that's how I felt. When I was drinking too much and I couldn't seem to stop, I just felt like I was a loser even though I was a successful doctor, a good dad pretty much most of the time. Right kids? That's debatable sometimes. We were just having this talk with my son at lunchtime. And he's going, "Oh, you were a good dad." And I'm thinking, "Well, but there were times when I wasn't available emotionally." So we beat ourselves up.

Dr. Sepalla: Yep, there's no way around it, I think, in the course of addiction. I hated myself. And I didn't know what was wrong. I had no idea I was an addict. And that guilt and shame just, it was piled on my shoulder. I couldn't believe that unless I was just completely wasted. And even then, it would sneak in to this horrible feeling.

Dr. Thomas: So now you're running the largest non-profit treatment center system in the country. That working to keep you sober?

Dr. Sepalla: No, that doesn't help--

Dr. Thomas: That doesn't help?

Dr. Sepalla: anybody to stay sober. No, I guess I shouldn't say that. I think gainful work and feeling good about one's self in that regard does help to lead a good life. But stress with any job does put one at risk for relapse because stressful situations actually are associated with drug and alcohol use, and with addiction, and with relapse.

But yeah, I love my job. I get to do a lot of remarkable things and see all kinds of people address their addiction. And every job has things you don't like. Mine's travel after travel all over the place.

Dr. Thomas: You are traveling a lot. I know. And I learned in a 12-step program, "HALT." These were things I was taught: hungry, angry, lonely, tired, avoid those things. Those are stressors. And when we're stressed out, we're at risk for relapse. So first you've got to get into treatment if you need treatment.

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And then if you're in the journey of recovery, which by the way is an amazing life compared to being stuck in our addiction, we need to do relapse prevention. What are the keys for relapse prevention? What would you suggest there?

Dr. Sepalla: Yeah, it's interesting because George Vaillant, Harvard psychiatrist, retired now for the most part, but an author, as well, he described longstanding research he did out of a project with Harvard students that started long before his involvement. But they looked at these 18-year-old guys. It started just with men, unfortunately. And they followed them into their 70s. And they looked at adult development.

Well, when you take a bunch of Harvard students—they also compared them to a cohort of Boston-area 18-year-olds and followed them, too—you got a bunch of alcoholics. He, at one point in his career, was asked to look at the alcoholics in this study. And so he did. And he also, another part of his career, he did a lot of work with heroin addicts. And he wanted to understand what keeps people sober? What's relapse prevention really about? How does that work?

And he found four things that he described or really associated with relapse prevention. So an alternative obsession or compulsion was one of them. And some people say that people attend 12-step meetings too often. And that can be an alternative thing.

Dr. Thomas: That can be an alternative. Exercise might be an alternative.

Dr. Sepalla: Exercise, yeah, yeah. And when I was first sober, I did all kinds of things way too much. For a while, I learned how to fly fish. I was doing that five, six, seven times a week. And yet, when I look back on that, that helped me stay sober. Just like he said. And it was overdoing it. But it really didn't matter. I was fly fishing. So what? And then, over time, I realized, "Man, I'm fly fishing too much." So then, I read too much. And then, I went to school and studied too much.

Dr. Thomas: You studied too much.

Dr. Sepalla: Yeah, man, so good things came out of it.

Dr. Thomas: Good things come of it, yeah.

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Dr. Sepalla: That's one of the things. And then, an external person in your life like a coach basically. So in that regard it's like a 12-step meeting sponsor, but he likened it to like a professional athlete. Professional athletes don't come up with their own training programs. They don't come up with their own regiments.

Dr. Thomas: They have a coach.

Dr. Sepalla: They have coaches--

Dr. Thomas: They have several.

Dr. Sepalla: that tell them exactly what to do
Dr. Thomas: Yeah, we all need life coaches.

Dr. Sepalla: We do, yeah. And he said that was another feature. The third feature was a religious or a spiritual experience and significant change in that manner because there are people who never attend 12-step meetings. Never go on medications for addiction. Never go to treatment. Walk into a church. And all of a sudden, somehow get something out of it. I don't think it's a large percentage. But it's a small group. And suddenly, they're done. And it's over.

But he said that that is really powerful long term in relapse prevention, as well as a new love interest. Now, part of that is related to, in the midst of our addictions, we often burn a lot of bridges with the people closest to us. And even if we're still involved with them, the interactions may not be what they once were. And they're often just fraught with a lot of difficulty. And a new love interest, not necessarily a romantic or sexual interest, but someone in life that you can really relate to, count on, and interact with in that real special way.

Dr. Thomas: A person with passion.

Dr. Sepalla: A person, in this case, yeah. And interestingly, that can be any number of people that's in one's life. It could be a co-worker. It could be someone at a meeting, a 12-step meeting. It could be just about anybody. But somebody else to be able to, just because of the difficulties we've caused in so many other relationships, to start a new with somebody that accepts us in a new way.

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So those four things are what he found are really about that. What I add to that is, also what he went past all that with, was to say, you can get all four of those things in 12-step meetings. They're all there.

Dr. Thomas: It's all there.

Dr. Sepalla: Yeah. And he, also, in his study, long-term study, found that of the group that long-term recovery, they attended like several hundred 12-step meetings early in their recovery. The group that didn't get sober attended less than 20 12-step meetings. And it doesn't take a statistician--

Dr. Thomas: To see that difference.

Dr. Sepalla: to look at that data the way he described it.

Dr. Thomas: Yep. Well, that fits my experience. You need to have something that you're passionate about that you can replace that energy that you were just drowning in your addiction. And then just being connected. You've got to be connected. And you've got to be following something passionate and having healthy relationships that come in there. And so thank you for sharing that. That's powerful.

I'd like to just give you a chance to add whatever else you want to tell our audience. Parting words from my good friend and probably favorite addictionologist in the entire world.

Dr. Sepalla: Well, thanks, Paul. Man. So it reminded me, talking about George Vaillant and relapse prevention, that he wrote a book called, *Spiritual Revolution*. And that book, he used a new theory of psychology about the positive emotions to make an argument for further examination of the positive emotions and trying to come to understand them in a way that could help with personal healing.

And at the end of the book, the example he uses is 12-step meetings are where you can get, more than anywhere else that he's aware of, involved in these positive emotions. And the positive emotion research that's going on in psychology right now is really profound. It is showing that love itself, not the kind of love after 40 years of marriage that we call love, but has to do with commitment, and bonding, and a life journey, but a love at a physiological level when two individuals are connected at a deep level in a moment.

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And it could be with a spouse. It could be with a stranger. But in that moment, that just lasts seconds or minutes have this really special connection physiologically, has to do with love itself. That's how this school of psychology is describing it so that we can experience love in almost any moment, with almost any other individual. It doesn't have to be someone in our family or someone we're close to.

And that the more we do that, the more our brains change. And those changes actually have to do with improving cognition, which is fascinating to me that you could improve your ability to think and everything just by expressing love to another individual.

It's also that research has shown improving health because they use an examination of vagal tone. And vagal tone has to do with heart health, in particular, but also other internal organ health. And vagal tone's a set thing that you can measure and associated with the relationship between breathing rate and heartbeat.

Dr. Thomas: Heart rate variability things.

Dr. Sepalla: Yeah. And you can improve. It's hard to change. It's hard to improve vagal tone. But expression of love, on a regular basis, will do it. And then, the third thing they've shown is resiliency, that improved resiliency with expression of love on a regular basis. And it's a hard research because it's research. So it's got to be really distinct.

Dr. Thomas: Yeah, that's love.

Dr. Sepalla: Yeah, that's love. And so--

Dr. Thomas: How do you research love?

Dr. Sepalla: Yeah, yeah. And, to me, that is probably the most fascinating movement in psychology today or in our understanding of being human and what that means. And it fits with all the perennial philosophies that talk about love. Every religion talks about love and the power of love.

And now, we're getting this science behind it showing us all these amazing things. And so that's how I want to end my career is looking at the effect of the positive emotions, especially love because it's the superior of the positive emotions and how that can really affect health and healing.

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Dr. Thomas: Thank you, Mark. The power of love. When I feel it, when you feel it, you know it.

Dr. Sepalla: Yeah, oh, yeah.

Dr. Thomas: You know it.

Dr. Sepalla: It's remarkable.

Dr. Thomas: And it's what we sometimes are so lacking in our disjointed, busy lives. So when you get an opportunity to feel that, just pursue that.

Dr. Sepalla: The people doing this research are saying that it's innate to us, as humans, to love one another. And we probably evolved because if you were alone on the Savannah with dinosaurs and sabre tooth tigers, you were screwed. You're not going to make it. You're going to die.

Dr. Thomas: You're not going to make it. You need nurture and love.

Dr. Sepalla: And if you're in a group, if you have friends around, you got a chance. And so the suggestion is that, from an evolutionary basis, our brain started changing to respond to each other with love to keep us alive.

And then when agriculture started and I'm growing my corn over here, but this group over here has no food because it's a tough winter. And all they do is hunt. And I can give them some of my stores of food. Maybe I should do that to help them stay alive. When survival itself is really the individual, that's the most important thing to anybody, is at a subconscious level, is personal survival.

But somehow as human beings, we were able to evolve in a way to get pass that to say, "I'll take care of you, too." That had to be just a remarkable shift because the animals don't do that, for the most part. Mothers do it for their children. The mammals do. But otherwise, it's not going on a whole lot.

And we have this incredible brain that has shifted in a way to allow that to happen. And if it's happened that way, then the possibility exists for continued positive changes of that nature, which is hard to think about in the midst of current circumstances politically and worldwide in so many ways. But I think that--

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Dr. Thomas: Start local. Start with your loved ones. Start with your family. Start with your friends. Start in your local community. And you give love. When I was in my addiction—you said it yourself at the beginning of our talk—we're selfish. "Those AA guys died." And you didn't notice, basically. That's how I was early in my addiction. It was all about me. "What could I get?"

And as I've grown, and matured, and I think have been able to give without necessarily needing something back, the rewards are amazing. And that's like love.

Dr. Sepalla: Yeah, it is.

Dr. Thomas: Yeah, and it's powerful. Thank you. I think that wraps up our talk with Dr. Marv Sepalla unless you have another because you're just full of this like can't get enough of this man. We're going to end on love. But if you have a final exclamation point, "Boom!" It's go for it.

Dr. Sepalla: That's it. That's it. I kid you not.

Dr. Thomas: That's it. Thank you, Marv.

Dr. Sepalla: Thank you, Paul.

Dr. Thomas: Dr. Sepalla, a real leader in our country in the addiction world. And this was a powerful share that you've really given our audience. And I can't thank you enough. Thanks for watching.

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