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Medical Treatment:
Managing Pain and Medication in Recovery[1]

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Introduction to the author

*This article was prepared by Stephen F. Grinstead, Dr.AD, and is an update to a **Journal** article written by Dr. Grinstead in 2002 (Grinstead, S.F. (2002), Managing Pain Medication in Recovery, **Journal of Addictive Disorders**, Breining Institute).*

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COURSE MATERIAL

Since 1984 I've worked with many people living with chronic pain who also had coexisting problems, including addiction. I also had the opportunity to help many people who were in recovery from an addictive disorder and also suffering with chronic pain, learn how to manage their condition without endangering their recovery or relapsing.

The most important thing that I've learned from my personal and clinical experience is that an integrated multidisciplinary team will produce the best outcomes for effectively managing a chronic pain condition. This is even more important when other psychological disorders are present, such anxiety, depression, trauma and especially addiction.

Chronic pain is a serious health crisis confronting many people today. According to recent research by the Institute of Medicine it currently affects well over 100 million American adults

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and is estimated that an excess of $600 Billion per year is spent on medical costs and lost productivity.

Pain is disabling for many people, and sometimes there are few safe alternatives available when they are seeking help. As a result, patients end up suffering or developing an addiction to the medications they are using to help manage their pain. Rod Clovin, in his book Prescription Drug Addiction, states that in 1999 more than 9 million people reported abusing their prescription medication.

If there are over 100 million people with chronic pain in the United States and it is estimated that conservatively about ten percent of these people are experiencing either abuse or addiction problems with their prescription medications. Also, people who are in chemical-dependency recovery face potential relapse or sometimes death from their addiction as a result of an untreated—or mistreated—chronic pain condition.

Managing chronic pain can be a challenging process, but it becomes even more difficult when a coexisting addictive disorder is also present. Historically, pain disorders and addictive disorders have been treated as separate issues. Pain clinics experience immense success in treating many chronic pain conditions. Chemical dependency treatment is successful in treating addictive disorders. However, the effectiveness of either one of these modalities is considerably reduced when the person is suffering from both conditions, as well as other coexisting problems that occur as a direct result of the pain and/or addictive disorder.

I personally have seen many recovering people relapse and even die as a result of a chronic pain condition that was neglected or ineffectively treated. As someone with personal experience of chronic pain, I became committed to finding a solution to this challenge. As a result, since 1996 I have been developing and updating the Addiction-Free Pain Management® (APM™) system. The goal of this course is to disseminate what I have learned since the Addiction-Free Pain Management® *Professional Guide* was published in 1999. Since that time I have also published *Managing Pain and Coexisting Disorders* in 2007 and *Freedom From Suffering: A Journey of Hope* in 2011.

Determining the outcome of treatment for chronic pain with a coexisting addictive disorder is complex due to what I have termed the Addiction Pain Syndrome™. You have an opportunity to explore this syndrome in the first chapter. I do not believe it is enough for patients to achieve only abstinence from inappropriate medication. Effective treatment for someone with an addictive disorder and chronic pain requires a three-part approach:

(1) Medication management plan—developed in consultation with an addiction medicine specialist

(2) Cognitive-behavioral treatment plan—which addresses the psychological/emotional components of pain and support in changing self-defeating behaviors

(3) Nonpharmacological pain management plan—which includes a tool box of safer chemical-free ways to manage chronic pain and pain flare-ups. The Addiction-Free Pain Management® system is a strategic combination of all three components working together utilizing a multidisciplinary and integrated pain management approach.

Recovery and avoiding relapse is possible if the patient is willing to do the footwork and follow this plan using a collaborative multidisciplinary treatment team. With the proper treatment plan and positive support, patients with chronic pain and coexisting disorders can have successful treatment outcomes. They can become proactive participants in their healing process instead of being a passive recipient (i.e., victim). This shift allows pain patients to become empowered and enables them to experience a better quality of life.

Beware of the Quick Fix Trap

When someone is living with chronic pain, they can get very frustrated when they aren't receiving the pain relief they want and deserve. I know because when I experience a pain flare up, I just want the pain to stop—now! People in pain have come to expect instant relief through pharmaceutical advertising on TV, radio and in magazines—they want relief and they want it as quick as possible. But when pain medications, which were originally developed for acute pain, are used for chronic conditions, people often get into trouble. While acute pain medication does give them the relief they are looking for, it can also reinforce their anticipation of a quick fix and lead to potential problems.

Knowing the difference between appropriate and effective use of pain medication and the beginning of abuse is sometimes difficult to determine. Even so, there are progressive stages that include: medication dependency, medication abuse, pseudoaddiction, and finally addiction. The confusion and uncertainty of this progression can be challenging for the person in pain and their treatment providers.

Some people living with chronic pain are afraid to take their narcotic medication (opiates etc.) because they have heard horror stories of people becoming addicted to their pain pills. This can lead to a decision to under-medicate, live in pain, and suffer. If someone is in recovery for alcoholism or any other drug addiction, the problem is even worse. If they under-medicate they will try to manage their pain however they can, potentially triggering a relapse. Or they overmedicate which could lead to a rapid tolerance buildup and finally a reactivation of their addiction.

Addressing Chronic Pain and Substance Use Disorders

A number questions need to be dealt with when assessing chronic pain and coexisting substance use disorders. At my Addiction-Free Pain Management® trainings here are the three most important ones I educate participants about:

1. Are we managing pain but fueling the addiction?
2. Are we treating the addiction but sabotaging the pain management?
3. Is it addiction or pseudoaddiction?

The first two questions are about the biases clinicians might be holding about people suffering with pain and addiction issues, specifically those in the Medical and Addiction communities. These might include: minimizing the seriousness of their pain, implying that "it's all in their head," believing they did it to themselves, or accusing them of med/drug seeking behaviors.

This plus other obstacles such as not recognizing co-existing disorders and family system problems can get in the way of effective treatment.

What we need are multidisciplinary treatment teams to address the complex nature of pain and coexisting disorders. I have long advocated for collaboration that concurrently treats the addiction and chronic pain disorder, as well as any other psychological problems.

The third question looks at pseudoaddiction which is fairly new term in the addiction treatment field, but has been used in pain management treatment for quite some time. It describes patient behaviors that may occur when pain is undertreated. People with unrelieved pain may become focused on obtaining medications, will clock watch, or otherwise seem to be inappropriately drug seeking. Even such behaviors as illicit drug use and deception can occur in the person's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors will resolve once the pain is effectively treated. Again,

- Pseudoaddiction looks a lot like addiction
- Patients may appear to be "Drug-Seeking"
- Patients may need frequent early refills
- Behaviors are caused by under-treatment
- Problematic behaviors resolve when the patient's pain is adequately treated

I have worked with many patients over the years that were labeled prescription drug addicts, but the correct diagnosis was more accurately pseudoaddiction. One of the assessment tools I developed helps in making this differentiation. *APM™ Module One: Understanding and Evaluating Your Chronic Pain Symptoms,* evaluates the ratio of physiological to psychological pain symptoms a patient is experiencing. This has been one of the most requested instruments by treatment providers when there is a question about addiction versus pseudoaddiction. Another indication of possible pseudoaddiction is co-existing disorders such as depression or a trauma history. In fact, 100 percent of the patients I see who experience true physiological chronic pain and true addiction have preexisting trauma which I believe must be addressed concurrently.

The point to remember is that even though pseudoaddiction looks like addiction, it is actually caused by an undertreated or mistreated chronic pain condition. However, the treatment plan for pseudoaddiction and addiction is identical. The major danger of pseudoaddiction is that if it is not adequately addressed, it can turn into full blown addiction—sometimes quickly, sometimes slowly.

Understanding Pain and Addiction

Addiction-Free Pain Management® (APM) is a treatment system for managing chronic pain by incorporating an effective medication management protocol, teaching patients to cope with the psychological/emotional components of pain, as well as developing nonpharmacological pain management interventions. To fully understand the APM™ system, three major concepts need to be clearly defined: (1) addiction, (2) pain, and (3) the pain system.

This section focuses on the addictive disorders, the pain disorders, and understanding the human pain system. The following chapter will discuss and define the Addiction-Free Pain Management™ system. Let's start by looking at addiction.

Understanding Addictive Disorders

This course uses the terms addictive disorders and addiction to discuss what the DSM-IV-TRTM (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision) classifies as substance use disorders and others refer to as chemical dependency or psychological dependence. You will find the DSM-IV-TR criteria for substance abuse and substance dependency in a table in Chapter Four, as well as the diagnostic criteria for pain disorders. As we know the DSM 5 is now available but for this course I will be using the DSM-IV-TR version.

In this course one of the definitions for an addictive disorder is: a collection of symptoms (i.e., a syndrome) that is caused by a pathological response to the ingestion of mood-altering substances and has ten major characteristics. These characteristics are shown in the following table. The table is followed by a brief explanation of each characteristic.

Addictive Disorder Symptoms

1.	Euphoria	6.	Inability to Abstain
2.	Craving	7.	Addiction-Centered Lifestyle
3.	Tolerance	8.	Addictive Lifestyle Losses
4.	Loss of Control	9.	Continued Use Despite Problems
5.	Withdrawal	10.	Substance-Induced Organic Mental Disorders

Let's look at each of these characteristics in a little more detail.

Euphoria

People use drugs because they work—they meet some kind of need. This is true of pain medications as well as other potential drugs of abuse. In addition to blocking physical pain, one of the side effects of some pain medications can be a sense of euphoria. If a person experiences this unique sense of well-being or euphoria when they use a drug or medication, they are at high risk of becoming psychologically dependent and may even become addicted to that substance.

Positive Reinforcement for Use

Recent research shows that when a person is genetically susceptible to being addicted to a specific drug, their brain will release large amounts of brain-reward chemicals whenever that

drug is used. It is this high level of brain-reward chemicals that causes the unique feeling of well-being that many addicts experience when using their drug of choice. In this book we will call this unique feeling of well-being—euphoria.

Euphoria versus Intoxication

It is important to distinguish between euphoria (the unique sense of well-being experienced when using a drug of choice) and intoxication (the symptoms of dysfunction that occur when a person's use exceeds the limits of their tolerance to a drug). Most addicts do not use their drug of choice to get intoxicated and become dysfunctional. The opposite is true. For instance, people who become addicted to prescription medication at first use it to manage physical pain, but at other times they use it to feel good and experience a unique feeling of well-being that will allow them to function better—or, in many cases, experience the illusion of functioning better.

People can actually become addicted to this state of euphoria. They crave this unique sense of well-being and feel somehow empty, incomplete, or deprived when they can't feel this way. They may even experience deprivation anxiety, which is a fear that if they can't get their drug of choice (or are deprived of it) they mistakenly believe they won't ever be able to feel good or function normally again.

Positive reinforcement leads to cravings.

This positive reinforcement is biopsychosocial in nature. Biologically, the drug of choice causes a release of pleasure chemicals that create a unique sense of well-being. Psychologically, "I come to believe the drug is good for me because it makes me feel good in the moment." This is called emotional reasoning. ("If it feels good, it must be good for me.") They then begin adjusting their social network to accommodate these beliefs. "Anyone who supports the use of my drug of choice is my friend. Anyone who challenges the use of my drug of choice is my enemy." The result is the development of a drug-centered lifestyle.

The stronger the positive reinforcement experienced when a person uses their medication, the greater their risk of becoming addicted to that drug. This is true because strong biological reinforcement from drug use creates a craving cycle.

Craving

The addictive process starts when someone receives a reward, payoff, or gratification from taking a psychoactive (mood-altering) drug. This reward may be the relief of pain or the creation of a sense of euphoria. Because the drug provides a quick positive reward, the person continues to use it.

With a pattern of consistent drug use, some people come to rely heavily upon the drug to provide that reward. This leads to an addictive disorder, or what is called "substance dependence" by DSM-IV-TR. People need to use the drug to successfully accomplish one or more life tasks. Once people become addicted, they experience psychological distress when the thing they are dependent upon is removed. When people become addicted to medication for relief or euphoria, they experience anxiety when the drug is no longer available. Albert Ellis calls

this deprivation anxiety. The person is anxious because he or she has been deprived of a drug they believe they need in order to function normally.

This deprivation anxiety then causes the person to start thinking about the drug. Obsession is the out-of-control thinking about the reward that could be achieved by using the substance. Obsession can lead to compulsion—the irrational desire for the drug. Obsession and compulsion combine together to create a powerful craving or a feeling of need for the drug.

Obsession + Compulsion = Craving

This cycle of obsession, compulsion, and craving creates a strong urge or pressure to seek out and use the medication even if the person consciously knows that it is not in his or her best interest to do so. Over time this reward continues to be reinforced, leading to an increased need for the drug. This leads to tolerance.

Tolerance

There is a definite biological component to developing tolerance. The increased need for the substance leads to drug-seeking behavior. There are also psychological and social components to this developmental process.

On the biological level, after drug-seeking behavior has been established, the brain undergoes certain adaptive changes in order to continue functioning despite the presence of the drug. This adaptation is called tolerance. When tolerance occurs, the brain chemistry of the user actually changes; there is a development of more receptor sites in the brain.

Psychologically, the person starts believing they need the drug. When people start to experience difficulty obtaining enough of the drug, they begin to feel anxious and afraid. Socially, they experience difficulty with other people because of the time and energy they are expending, resulting in loss of control.

Loss of Control

The final stage of the craving cycle and development of tolerance is the loss of control people feel over their medication use and/or their behavior while using the drug. The person begins to develop an even higher tolerance for the drug. In other words, it takes more of the drug to get the same effect. If the person keeps using the same amount of the drug, they experience less of an effect. So the person begins using more of the medication or seeking out stronger drugs, including alcohol, that will give the same, or better, reinforcing effect.

At times the medication and/or other drugs are taken in such large quantities that the person becomes intoxicated or dysfunctional. This dysfunction creates biopsychosocial life problems. At this point, if the person stops using the drug, they will experience uncomfortable physical and emotional problems. This leads to lowered motivation to stop the drug use.

Withdrawal

Withdrawal is marked by the development of a specific clinical syndrome upon the cessation of medication use. In some cases patients may use the same or a similar drug to relieve or avoid the withdrawal syndrome.

Withdrawal as Negative Reinforcement (Mental Anguish or Dysphoria)

Once tolerance and loss of control take place, further abnormalities occur in the brain when drugs are removed. In other words, the brain loses it capacity to function normally when drugs are not present.

- Low-grade abstinence-based brain dysfunction is distinct and different from the traditional acute withdrawal syndromes.
- Low-grade abstinence-based brain dysfunction is marked by feelings of discomfort, increased cravings, and difficulty finding gratification from other behaviors.
- Low-grade abstinence-based brain dysfunction creates a desire to avoid the unpleasant sensations that occur in abstinence.
- The desire to avoid painful stimuli is called negative reinforcement.
- People who experience biological reinforcement are more likely to use drugs regularly and heavily.
- People who use drugs regularly and heavily are more likely to develop an addictive disorder.

Inability to Abstain

As a result of experiences created by biological reinforcement and high tolerance, patients come to believe their drug of choice is good for them and will magically fix them or make them better. They start to develop an addictive belief system. They come to view people who support their drug use as friends and people who fail to support it as their enemies.

Addictive Beliefs

At this point the person is experiencing both positive and negative reinforcement to keep using. If they continue to use, they experience euphoria and pain relief. This occurs because the brain releases large amounts of reward chemicals when they use their drug of choice. At this point they are totally unable and/or unwilling to adhere to the medication management plan they agreed to follow with their health-care provider.

If they stop using, they experience dysphoria or pain and suffering. They start to experience a sense of anhedonia that is marked by a low-grade agitated depression and the inability to experience pleasure. They begin to believe they have no choice but to keep using their drug of choice.

Addiction-Centered Lifestyle

An addiction-centered lifestyle develops when the person attracts and is attracted to other individuals who share strong positive attitudes toward the continued use of drugs (i.e., the problematic pain medication). These people usually have enabling support systems that condone and encourage their continued use. They become immersed in an addiction-centered system.

Addictive Lifestyle Losses

Addicted people distance themselves from those who support sobriety or effective medication management and surround themselves with people who support problematic medication use and/or alcohol and other drug use. The pattern of biological reinforcement has motivated them to build a belief system and lifestyle that supports heavy and regular use.

A Pattern of Heavy and Regular Use

Such people are now in a position where they will voluntarily use larger amounts with greater frequency until progressive addiction and the accompanying physical, psychological, and social degeneration occur. Their lives become unbearable and unmanageable. They start experiencing a downward spiral of problems—addictive lifestyle losses.

Continued Use Despite Problems

Unfortunately, this downward spiral leads to continued drug use despite the consequences. This inability to control drug use causes problems. The problems cause pain. The pain activates a craving. The craving drives people to start using the drug to get the relief they believe they need.

As a result, when addicted people experience adverse consequences from their addiction, these consequences cause cravings instead of correction. As a result, addicted people keep using drugs to gain the immediate reward or relief despite experiencing serious life problems.

Substance-Induced Organic Mental Disorders

The progressive damage of pain medication and/or alcohol and other drugs on the brain create growing problems with judgment and impulse control. As a result, behavior begins to spiral out of control. The cognitive capacities needed to think abstractly about the problem have also been impaired, and the addicted person is locked into a pattern marked by denial and circular systems of reasoning. There will be more about denial in a later chapter.

Progressive neurological and neuropsychological impairments will lead to denial

At this stage addicted people are unable to recognize the pattern of problems related to their drug of choice. When problems do occur, they begin to experience physical, psychological, and social deterioration. Unless they develop an unexpected insight or are confronted by a

motivational crisis or by concerned people in their life, the progressive problems are likely to continue until serious damage results.

Defining Misunderstood Terms

There needs to be clarification when choosing words to describe people on long-term pain medication use. Many patients are identified or labeled as “addicts” when in fact they are definitely not. To help clarify this issue a consensus document was developed in 2004 by the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine. They agreed upon the following definitions for addiction, physical dependence, tolerance, and pseudoaddiction.

Addiction

Addiction is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical Dependence

Physical dependence is a state of adaptation that is manifested by a drug class- specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance

Tolerance is a state of adaptation where exposure to a drug induces changes resulting in a diminution (lessening) of one or more of the drug’s effects over time.

Addiction versus Pseudoaddiction

Pseudoaddiction

The term pseudoaddiction has developed over the past several years in an attempt to explain and understand how some chronic pain patients exhibit many red flags that look like addiction. Pseudoaddiction is a term used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may clock watch, and may otherwise seem inappropriately drug seeking. Even such behaviors as illicit drug use and deception can occur in the patient’s efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when the pain is effectively treated.

Pseudotolerance

Dr. William W. Deardorff (2004) advocates the importance of differentiating tolerance (described previously) and pseudotolerance. He describes pseudotolerance as the need to increase dosage that is not due to tolerance but due to other factors such as changes in the disease, inadequate pain relief, change in other medication, increased physical activity, drug interactions, lack of compliance, etc. Patient behavior indicative of pseudotolerance may include drug seeking, clock watching for dosing, and even illicit drug use in an effort to obtain relief. Like pseudoaddiction, pseudotolerance can be distinguished from tolerance in that the behaviors resolve once the pain is effectively treated.

In addition to understanding addictive disorders, pain patients must also understand what pain is and the biopsychosocial processes that influence it in order to efficiently use the APM™ clinical system.

Understanding Pain Disorders

An Overview of the Biopsychosocial Components of Pain

To understand pain management it is important to understand the concept of pain. Pain is a signal from the body to the brain that communicates that something is wrong. There are three components of pain—biological, psychological, and social/cultural.

Deardorff (2004) emphasizes that pain is not easy to define. But in 1979 the International Association for the Study of Pain (IASP) published its first working definition of pain: “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

This definition was reaffirmed in 1994 along with an extensive footnote discussion regarding its implications. The IASP definition acknowledges that, for most people, tissue damage is the “gold standard” by which pain is understood. However, the definition also recognizes that pain may occur in the absence of tissue damage and is impacted by emotional (psychological) factors.

In a footnote explaining the definition, the authors point out that pain is not equivalent to the process by which the signal of tissue damage is passed through the nervous system to the brain (this is called nociception); rather, pain is always a psychological state that cannot be reduced to objective signs. In other words, ***pain is always subjective***.

Pain is a signal from the body to the brain that communicates that something is wrong

Pain is a total biopsychosocial experience. A person hurts physically. They psychologically respond to the pain by thinking, feeling, and acting. They think about the pain and try to figure out what is causing it and why they are hurting. They experience emotional reactions to the pain and may get angry, frightened, or frustrated. They will talk about their pain with family, friends,

and coworkers who help them develop a social and cultural context for assigning meaning to their personal pain experience, which leads to taking appropriate action.

Three Essential Levels of Pain Management

Successful pain management systematically approaches the treatment of pain at three levels (bio-psycho-social) simultaneously. This means using physical treatments to reduce the intensity of the physical pain. It also means using psychological treatments to identify and change the thoughts, feelings, and behaviors that are making the pain more intense or distressing and replacing them with positive thinking, as well as using feeling and behavior management skills that can reduce the intensity of the pain.

Therefore, effective pain management must involve not only the patient, but also the significant people in their life who can help them develop a social and cultural context to experience their pain in a way that reduces suffering.

Biological pain is a signal that something is going wrong with the body. The biological, or physical, pain sensations are critical to human survival. Without pain, people would have no way of knowing that something was wrong with their body. They would be unable to take action to correct the problem or deal with the situation that is causing the pain.

Psychological pain results from the meaning that the individual assigns to the pain signal. The psychological symptoms include both the cognitive (thinking changes) and emotional (uncomfortable feelings) that often lead to suffering. Most people are not able to differentiate between the physical and psychological. All they know is, “I hurt.” For effective pain management, patients need to learn all they can about their pain.

Social and cultural pain results from the social and cultural meaning assigned by other people to the pain the patient is experiencing, and whether or not the pain is recognized as being severe enough to warrant a socially-approved sick/injured role. These three components determine whether the signal from the body to the brain is interpreted as pain or suffering.

Imagine the following vignette: Bob is his college’s star football player. In the previous week’s homecoming game Bob scored the winning touchdown but broke his arm in the process. This week Bob is sitting on the bench with a cast on his arm that everyone has signed. This cast and how he earned it are seen as an honorable reason for him to be sitting on the bench instead of being out on the field helping his team. But, in that same game, Karl, a big hulking lineman, “tweaked” his back and was also sitting on the bench. Unlike Bob, Karl doesn’t have an observable injury, and people keep asking him why he isn’t out on the field helping his team. Karl is much more apt to experience shame/guilt than Bob, which will probably amplify his pain symptoms.

Pain versus Suffering

The psychological meaning that the individual assigns to the physical pain signal will determine whether they simply feel pain (“Ouch, this hurts!”) or experience suffering (“Because I hurt, something awful or terrible is happening!”). Although pain and suffering are often used

interchangeably, there is an important distinction that needs to be made. Pain is an unpleasant signal telling people that something is wrong with their body. Suffering results from the meaning or interpretation the brain assigns to the pain signal.

Pain is "biopsychosocial"

Biological Pain: A signal that something is going wrong with the body

Psychological Pain: The meaning that people assign to the pain signal

Social/Cultural Pain: The approved "sick" role assigned to people by society concerning their pain

Many people irrationally believe: "I shouldn't have pain!" or "Because I have pain and I'm having trouble managing my pain, there must be something wrong with me." A big step toward effective pain management occurs when patients can reduce their level of suffering by identifying and changing their irrational thinking and beliefs about pain, which in turn decreases their stress and overall suffering.

Because of the two parts—pain and suffering—pain management must also have two components: physical and psychological. The way patients sense or experience pain—its intensity and duration—will affect how well they are able to manage it. The research on recovery from chronic pain is very clear. The patients that are most likely to successfully manage their pain do so by becoming proactively involved in their own treatment process. The chances of success go up as patients start learning as much as possible about their pain and effective pain management.

People manage their pain more effectively when they stop being a passive recipient and start becoming an active participant in their treatment.

Psychological treatment for chronic pain is meant to supplement medication treatment, not replace it. Emotional stress and negative thinking can actually increase the intensity of the pain, but the presence of psychological factors doesn't mean that the pain is imaginary. Psychological treatment goals are designed to help people learn how to understand, predict, and manage their pain cycles; use coping skills to minimize their pain; and maximize active involvement in positive life experiences, despite the presence of chronic pain.

Breaking the pain cycle involves addressing the physiological as well as the psychological/emotional components of the pain. Stress also plays a role in keeping a pain cycle going. Stress causes muscle tension, which then leads to increased pain sensation. At the same time a person's cognition and emotions can also amplify this cycle. Breaking the pain cycle requires concurrent treatment of the physiological and psychological/emotional condition. See the following diagram for a visual of this pain cycle.

Additionally, psychological treatment for chronic pain focuses on the emotional toll people experience while living with pain on a daily basis. Important factors such as disability, financial stress, or loss of work are also a part of the pain picture, and psychological treatment is

designed to address all relevant issues. The treatment for chronic pain does not include magical interventions; rather, it includes a combination of proven psychological treatment approaches combined with medication management and other nonpharmacological interventions that address all the issues people in chronic pain experience.

Because of the two parts—pain and suffering—pain management must also have two components: physical and psychological. The way patients sense or experience pain—its intensity and duration—will affect how well they are able to manage it. In addition, there are three major classifications of pain that need clarification: acute pain, chronic pain, and recurrent acute pain.

Understanding and Addressing Chronic Pain and Addiction

Pain is the reason many people start using potentially addictive substances. We know that regular use of psychoactive medication plus a genetic or environmental susceptibility can lead from pain relief to increased tolerance. For someone in recovery from any addictive disorder pain is a major relapse trigger. A former patient of mine, Jeanie, is an excellent example of what can happen when a chronic pain condition is not managed appropriately and the treatment depends exclusively on medication.

Both of Jeanie's parents were alcoholics and she was in an abusive marriage. She developed a chronic pain condition and was prescribed opiate medication to treat it. Jeanie soon discovered that her pain medication also helped her escape from painful childhood memories and the trauma of being in an abusive relationship.

Eventually Jeanie's medication no longer helped with the physical pain symptoms or her emotional distress, so she started taking much more than was prescribed. She eventually went to several different doctors to get the amount she believed she needed, but her pain continued to get worse. In fact, Jeanie's medication started to increase or amplify her pain signals—this is sometimes called the pain-rebound effect.

Chronic medication use plus genetic or environmental susceptibility can lead to increased tolerance as a result of searching for pain relief. Eventually the addictive substance no longer manages the physical or psychological pain symptoms. Not only will it increase or amplify the pain signals—pain-rebound –it can also cause an extreme sensitivity to pain, a condition called opioid-induced hyperalgesia. The end result is severe biopsychosocial pain and problems.

Jeanie eventually became addicted to her medication, which increased her pain and created problems in every area of her life; physically, psychologically, and socially (biopsychosocial). Because Jeanie was experiencing both chronic pain and substance dependency problems, she needed a specialized concurrent treatment plan for both conditions.

An effective synergistic treatment protocol for Jeanie's chronic pain and substance addiction condition included the following three components:

Appropriate Medication Management: Jeanie's medication management plan included collaborating with an addiction medicine practitioner/specialist. This person made sure that her

medication was needed, was recovery friendly and was the right type, as well as the appropriate quantity and frequency so it would not trigger relapse.

Core Clinical Processes: Jeanie also needed to deal with her irrational thinking, uncomfortable emotions, and self-defeating urges and behaviors, as well as the isolation tendencies that often develop with co-existing pain and addiction. I used a cognitive behavioral therapy approach using the eight clinical processes in the *Addiction-Free Pain Management® Workbook* as a starting point which worked well as her health care provider was experienced in the concurrent treatment of chronic pain and substance dependency.

Nonpharmacological (Holistic) Interventions: I supported Jeanie to search out alternative non-pharmacological/holistic pain management modalities such as hydrotherapy, physical therapy, acupuncture, chiropractic, prayer, meditation, hypnosis, self-hypnosis, etc. I also suggested that she read *Managing Pain Before it Manages You* (2001), a book by Margaret Caudill, which was very helpful. Jeanie also used both 12-Step and chronic pain support groups, which greatly enhanced her recovery.

Knowledge is Power

Developing an effective treatment plan also required that Jeanie understand which stage of the addiction process she was in. It was also important for her to understand how much damage had been done through her inappropriate use of pain medication. As Jeanie progressed in treatment, she also learned how to identify which stage of the developmental recovery process she was in, and then implement appropriate treatment interventions.

As you can see, the road to recovery can be a difficult and challenging one for someone with both chronic pain and a coexisting addictive disorder. However, most of the chronic pain research I have reviewed over the past two decades has been very clear about treatment outcomes. The best prognosis is when people are proactive in their own treatment and recovery process and utilize a multidisciplinary approach. We need to support our patients to learn as much as they can about their pain and effective pain management interventions.

I have found that once people understand what is really going on with their body and mind, they can and often will, take action to effectively manage their pain. But remember as Kahil Gibran says in his book *The Prophet* “A little knowledge that acts, is worth infinitely more than much knowledge that is idle.”

In fact, the most important shift people suffering with chronic pain need to make is to let go of the self-defeating belief that pain is their enemy; they must come to terms with their pain and accept it as their friend. When I suggested this to Jeanie, she had a difficult time believing she could make peace with her pain as she had been at odds with her body and her pain for so long.

Whether or not patients believe it, I have found in the course of my work that this is, nevertheless true. It was very important for Jeanie to let go of seeing herself as a victim of her pain condition and empower herself by developing a pain management and chemical

dependency recovery program that worked for her. Fortunately, Jeanie adhered to her treatment plan and remained clean and sober, as well as effectively managing her chronic pain.

BIBLIOGRAPHY AND RECOMMENDED READING LIST

Barrett, S., et al. (2006) Consumer health: A guide to intelligent decisions. Columbus, OH: McGraw-Hill.

Boriskin, J. (2004). PTSD and addiction: A practical guide for clinicians and counselors. Center City, MN: Hazelden.

Campbell, J. et al. (2006). Emerging strategies for the treatment of neuropathic pain. Seattle, WA: International Association for the Study of Pain.

Carr, D., Loeser, J., & Morris, D. (2005). Narrative, pain, and suffering. Seattle, WA: IASP Press.

Catalano, E., & Hardin, K. (1996). The chronic pain control workbook: A step-by-step guide for coping with and overcoming pain. Oakland, CA: New Harbinger.

Caudill, M. (2001). Managing pain before it manages you. New York: Guilford Press.

Chino, A., & Davis, C. (2000). Validate your pain: Exposing the chronic pain cover-up. Stanford FL: Health Access Press.

Cleveland, M. (1999). Chronic illness and the twelve steps: A practical approach to spiritual resilience. Center City, MN: Hazelden.

Colvin, R. (2002). Prescription drug addiction: The hidden epidemic. Omaha, NE: Addicus Books.

Corey, D., & Solomon, S. (1989). Pain: Free yourself for life. New York: Penguin Books USA.

Davis, M. Eshelman, E. R., & McKay, M. (1995) The relaxation & stress reduction workbook, fourth edition. Oakland, CA: New Harbinger Publications, Inc.

Deardorff, W. (2004) The psychological management of chronic pain. Continuing Ed Courses.Net: www.continuingedcourses.net.

Deardorff, W., & Reeves, J. (1997). Preparing for surgery: A mind-body approach to enhance healing and recovery. Oakland, CA: New Harbinger Publications, Inc.

Egoscue, P. (1998). Pain Free: A revolutionary method for stopping chronic pain. New York, NY: Bantam.

Ford, N. (1994). Painstoppers: The magic of all-natural pain relief. West Nyack, NY: Parker.

Fuhr, A. (1995). Activator methods chiropractic technique: The science and art. Today's Chiropractic, July/August, 48-52.

Gatchel, R. & Turk, D. (1996). Psychological approaches to pain management. New York, London: The Guilford Press.

Gorski, T. (2010). Straight talk about suicide. Independence, MO: Herald House/Independence Press.

Gorski, T. (2006). Depression and relapse: A guide to recovery. Independence, MO: Herald House/Independence Press.

Gorski, T. & Grinstead, S., (2010) Relapse prevention therapy workbook: Revised, updated, and simplified. Independence, MO: Herald House/Independence Press.

Gorski, T. & Grinstead, S., (2006) Denial management counseling workbook, revised. Independence, MO: Herald House/Independence Press.

Gorski, T., & Grinstead, S. (2000) Denial management counseling professional guide. Independence, MO: Herald House/Independence Press.

Grant, M. (2005). Pain control with EMDR: An information processing approach. Submitted for publication.
Grinstead, S. (2008). 2nd edition. Addiction-free pain management® recovery guide: Managing pain and medication in recovery. Independence, MO: Herald House/Independence Press.
Grinstead, S. (2007). Managing pain and coexisting disorders: Using the addiction-free pain management® system. Independence, MO: Herald House/Independence Press.
Grinstead, S., Gorski, T., & Corbett S. (2007). Eating Addiction: The relapse prevention workbook. Independence, MO: Herald House/Independence Press.
Grinstead, S., Gorski, T., & Messier J. (2006). Denial management counseling for effective pain management. Independence, MO: Herald House/Independence Press.
Grinstead, S. & Gorski, T. (2006). Addiction-free pain management®: Relapse prevention counseling workbook, revised. Independence, MO: Herald House/Independence Press.
Grinstead, S. & Gorski, T. (1999). Addiction-free pain management®: The professional guide. Independence, MO: Herald House/Independence Press.
Khalsa, D. & Stauth, C. (2002). Meditation as medicine: Activate the power of your natural healing force. New York: Fireside.
Kennedy, J., & Crowley, T. (1990). Chronic pain and substance abuse: A pilot study of opioid maintenance. Journal of Substance Abuse Treatment, 7(4), 233-238.
Kingdon, R., Stanley, K. & Kizior, R. (1998). Handbook for pain management. Philadelphia, PA: W. B. Saunders.
Meade, T., et al. (1995). Randomized comparison of chiropractic and hospital outpatient management for low back pain: Results from extended follow-up. British Medical Journal, 311, 349-351.
Melzack, R. and Wall, P. (1965). Pain mechanisms: A new theory. Science, 150, 971-979.
Melzack, R. and Wall, P. (1982). The challenge of pain. New York: Basic Books.
Mersky, H., Loeser, J., & Dubner, R. editors (2005). The paths of pain: 1975-2005. Seattle WA: International Association for the Study of Pain.
Osterbauer, P., et al. (1992). Three-dimensional head kinetics and clinical outcome of patients with neck injury treated with manipulative therapy: A pilot study. Journal of Manipulative Physiological Therapy, 15(8), 501-511.
Pinsky, D., et al. (2004). When painkillers become dangerous. Center City, MN: Hazelden.
Reilly, R. (1993). Living with pain: A new approach to the management of chronic pain. Minneapolis: Deaconess.
Rogers, R., & McMillin, C. (1989). The healing bond: Treating addictions in groups. New York: W W Norton & Company.
Rome, J., (2002). 2nd edition. Mayo clinic on chronic pain. Rochester, MI: Mayo Clinic Health Information.
Rosenfeld, A., (2003) The truth about chronic pain. New York, NY: Basic Books.
Roy, R. (1992). The social context of the chronic pain sufferer. Toronto: University of Toronto Press.
Sarno, J. (1998). The mind body prescription: Healing the body healing the pain. New York: Warner Books.
Sarno, J. (1991). Healing back pain: The mind body connection. New York: Warner Books.
Stacy, C. Kaplan, A., & Williams, G. (1992). The fight against pain. New York: Consumers Union.
Stanford, M. (1998) Foundations in behavioral pharmacology: For social workers, psychologists, therapists, and counselors. Santa Cruz, CA: Lightway Centre.

Stimmel, B. (1997). Pain and its relief without addiction. New York: Haworth Medical.
Stimmel, B. (1983). Pain, analgesics, and addictions. New York: Raven.
St. Marie, B. & Arnold, S., Editors (2002). When Your Pain Flares Up. Minneapolis: Fairview Press.
Tennant, F., Shannon J., Nork, J., Sagherian, A., & Berman, M. (1991). Abnormal adrenal gland metabolism in opioid addicts: Implications for clinical treatment. Journal of Psychoactive Drugs, 23 (2), 135-149.
Turk, D., Rudy, T., & Sorkin, B. (1993). Neglected topics in chronic pain treatment outcome studies: Determination of success. Pain, 53 (1), 3-16.
Wall, P., & Jones, M. (1991). Defeating pain: The war against the silent epidemic. New York: Plenum.
Warfield, C. (1996). Expert pain management. Spring House, PA: Springhouse.
Watkins, J. , & Watkins, H. (1990). Dissociation and displacement : where goes the ouch? American Journal of Clinical Hypnosis, 33(1), 1-10.
Vertosick, F. (2000). Why we hurt: The natural history of pain. New York: Harcourt.
(2006). Substance Abuse in Brief Fact Sheet. Pain Management Without Psychological Dependence. Summer 2006, Vol 4 Issue 1: U.S. Department of Health and Human Services.
Young, M., & Baar, K. (2002). Women and pain: Why it hurts and what you can do. New York: Hyperion.

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