

Managing Chronic Pain and Prescription Drug Addiction

Today more than 57 percent of all U.S. adults experience chronic pain — which translates to about 117 million people (Hart, 2003). Surprisingly 18-34 year olds have been found to be as likely to experience chronic pain as older folks. Many of these people turn to pain medication to cope, and most people on appropriately prescribed pain medication don't experience any problems. However, about 5 percent to as high as 20 percent of people using psychoactive medication for pain management end up having either substance abuse or addiction issues (Grinstead, 2002; Stimmel, 1997). Using a conservative 10 percent estimate would mean that in 2003 about 11.7 million people with chronic pain were experiencing prescription drug abuse or addiction. Unfortunately, this problem only comes to the public's awareness when a nationally recognized personality is "caught" in the pain/addiction trap.

Prescription drug abuse vs. drug diversion

As these statistics indicate, the growing trend of prescription drug abuse is reaching alarming proportions in some areas of our country. The problem has two components, drug diversion for profit and drug abuse. There are several types of diversion for profit, including patients obtaining prescriptions from numerous doctors, forging prescriptions, or going to multiple pharmacies with the same prescription, and health care providers, pharmacy employees, and others diverting the medications for financial gain. The second component is chronic pain patients who abuse or become addicted to their medication and end up either doctor or pharmacy shopping in an attempt to manage their pain. Drug diversion obviously needs to include strong law enforcement interventions, but prescription drug abuse should be addressed as a healthcare or public health issue. Our goal here is to focus on identification and effective treatment of prescription drug abuse.

Medical science has significantly improved our quality of life with many new pharmaceutical products resulting in successful treatment of diseases and other medical conditions that historically have caused so much pain and suffering. The downside is that some of these medications are being abused. Some of the most abused pain management drugs include: hydrocodone (e.g., Vicodin®, Loratab®, Norco®), OxyContin®, Demerol®, morphine, methadone, Dilaudid®, Soma®, and the benzodiazepines: Valium®, Librium®, Xanax®, and Klonopin®. One of the major contributing factors to prescription drug abuse is ineffective or inappropriate chronic pain management. The simple fact is — people don't want to be in pain.

Defining misunderstood terms

There is quite a bit of confusion and mislabeling of people on long-term use of pain medication. Many patients are identified as "addicts" when in reality they are not. To help clarify this issue, a consensus document was developed by the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine (Savage, Covington, Heit, et al., 2004). They have agreed upon the following definitions for addiction, physical dependence, tolerance, and pseudo addiction:

Addiction. Addiction is a primary, chronic, neurobiologic 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 in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

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 that has been 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 pain is effectively treated.

Chronic pain concerns

As we saw earlier, chronic pain currently affects about 117 million American adults (Hart, 2003). Pain is disabling for many people, and when they seek help, they discover there are limited alternatives for effective pain relief. As a result, some patients may end up suffering or developing an addiction to the medications they are using to help manage their pain. People who are in recovery from chemical dependency can relapse and even die from their addiction as a result of an untreated—or mistreated—chronic pain condition.

Managing a chronic pain condition can be a very 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 have had great success in treating chronic pain conditions. Chemical dependency treatment is successful in treating addictive disorders. However, the effectiveness of either one of these modalities often fails when the person is suffering from both conditions.

Coexisting disorders. Since one of the major causes of prescription drug abuse is mismanaged chronic pain, it is crucial to identify the obstacles that can sabotage effective pain management. One major obstacle is when a coexisting psychological disorder or medical condition is not identified and treated. Two of the most common psychological conditions that tend to complicate many patients' effective treatment are depression and an underlying trauma history with untreated posttraumatic stress disorder (PTSD). Other serious and often overlooked psychological conditions include anxiety disorders, bipolar disorders, personality disorders, pain disorders, and sleep disorders.

Depression. Many patients with chronic pain frequently become depressed due to living with undertreated or mistreated pain symptoms. This process begins when their thinking and emotions become problematic. When their thinking becomes irrational or dysfunctional, they start mismanaging their feelings. They often have urges to indulge in self-defeating, impulsive or compulsive behaviors to cope with their depression — including medication, which impacts their relationships with others.

Support networks. For pain patients in chemical dependency recovery, a misguided support network may also play a role in sabotaging their treatment process. “Don't take anything — no matter what.” This statement can be heard frequently at Alcoholics Anonymous (AA) or Narcotic Anonymous (NA) meetings. The message is, if you don't use any alcohol or other drugs, you are clean and sober and will experience the promises of recovery, but if you take anything, “You've blown it! You've relapsed! You've failed!”

In most cases, those words are good counsel for patients recovering from chemical dependency. However, when the anything includes medication prescribed by a knowledgeable physician for a legitimate condition, those words could lead to a relapse. Some examples of appropriate medications often prescribed to people in recovery include antidepressants, anti-anxiety medication, or pain medication.

Misguided healthcare providers. Sometimes the problems facing pain patients in chemical dependency recovery are a result of the reactions from their healthcare providers and can occur

in one of two ways. The first is when the provider decides that, since their patient is an “addict,” it’s their policy not to prescribe any narcotic medication and the patient gets labeled as “drug seeking.” What is important to understand is that the patient in pain is not “drug seeking,” he or she is really seeking pain relief.

The other example is the doctor who thanks the patient for his or her honesty and is willing to prescribe narcotic medication, but does not fully understand addiction or recovery. The doctor might say something like “we’ll be careful, but just let me take care of what to prescribe.” Unless he or she is knowledgeable about addiction and recovery, this doctor’s lack of understanding could be a setup if his or her patient does not have an effective medication management and relapse prevention plan in place.

Undiagnosed medical conditions. In other cases, poor treatment progress is the result of an undiagnosed medical condition. For instance, a patient has gone months or years with a high level of chronic pain with an unknown pain generator source and is being treated with opiates to “keep them happy.” Some patients who experience this are fortunate when an insightful medical professional suggests appropriate diagnostic procedures that uncover the hidden problem, which leads to effective treatment interventions.

In many cases, however, the true cause of a patient’s chronic pain remains hidden. This can lead treatment professionals to either minimize the seriousness of the pain condition or imply that the pain is “all in the patient’s head.” When this happens, many patients feel either angry or ashamed. They doubt their own reality and eventually begin to believe that their healthcare provider must be right.

The roadblock called denial. Another major obstacle to effective pain treatment is the patient’s denial system. If patients do not realize how serious their problem really is, it can be extremely difficult to find a solution. Many people have a mistaken belief that “I can’t be addicted because I’m in pain and a doctor gave me the medication.” This can be a type of denial if in fact they have been abusing or are addicted to their medication and experiencing life-damaging consequences. Denial can be even more subtle than this — it can lead people to sabotage their healing by being resistant to following treatment recommendations (Gorski & Grinstead, 2000).

Treatment solutions

To effectively manage a pain condition, it is important that patients understand exactly what is going on with their body. When patients are in pain, they experience both physical and psychological symptoms. To understand the language of pain, patients must learn to listen to how the pain echoes and reverberates between the physical, psychological, and social dimensions of the human condition. Pain is truly a total human experience — one that affects all aspects of human functioning (Grinstead, 2002).

When patients are in pain for a long period of time, they can feel victimized by their pain. They may hate their pain. They may want to escape from their pain. They may even become willing to do anything to get relief. Unfortunately, many patients get that relief by using self-defeating behaviors, including the abuse of pain medication.

The literature and reports from organizations like the International Association for the Study of Pain and the American Chronic Pain Association often report that positive outcomes for chronic pain treatment is very clear. Patients most likely to successfully manage their pain become active participants in their treatment, not passive recipients. Their chances of success increase as they learn as much as possible about their pain and effective pain management.

Once patients know what is really going on with their body and mind, they can start to take action to effectively manage their pain. Patients must let go of the belief that pain is their enemy and embrace it as their friend. Many people, when introduced to the concept of making peace with their pain and that pain is their friend, are not willing to believe it. They often tell the provider — very strongly — that they can’t buy it, but nevertheless it is true.

To experience effective pain management, patients need to be educated about their pain. Pain sensations are essential for human survival. Without pain, people would have no way of knowing that something was wrong with their body. Furthermore, they would be unable to take action to correct the problem or situation that is causing the condition. Knowledge is power — patient education must be an integral part of an effective pain management treatment plan and should teach patients about the following points:

Physical and psychological pain. The psychological symptoms of chronic pain include both cognitive (thinking changes) and emotional (uncomfortable feelings) that lead to suffering and both need to be identified and treated. Most people have difficulty differentiating between their physical and psychological pain symptoms. All they know is “I hurt.” For effective pain management, people need to learn all they can about the psychological/emotional components of their pain and implement an appropriate treatment plan (Grinstead, 2002).

Acute and chronic pain. There are two types of pain that patients need to understand: acute and chronic. Acute pain tells the body that something has gone wrong or that damage to the system has occurred. The source of the pain can usually be identified easily and typically does not last very long. An example of acute pain is when someone touches a hot burner on the stove. Acute pain is mostly physical in nature, while chronic pain usually has a significant psychological component (Caudill, 2002; Sarno, 1998).

The treatment for acute pain conditions often depends primarily on medication and has a predictable healing process. When considering treatment for chronic pain, however, both medical and psychological interventions must be used. Chronic pain can be present because the body is not healing, or because physical damage is ongoing, such as arthritis, fibromyalgia, cancer, many traumatic injuries and some chronic illnesses. Additionally, chronic pain sometimes continues without a clear physical cause — the pain signal gets turned on and won't turn off.

How people amplify or demonize their pain

When medication doesn't eliminate the pain or address the lifestyle losses the person is experiencing, the result is usually irrational thinking and uncomfortable emotions; in other words, suffering. Some conditions — because they are terminal or likely to result in significant disability — may also evoke amplified pain symptoms because of the psychological components of the illness or injury.

The anticipation of an expected pain level can influence the degree to which patients experience pain. When the patient's self-talk is saying, “this is horrible, awful, terrible,” their brain tends to amplify the pain signal. When this occurs, their level of distress increases and they suffer, remaining a victim of pain.

The anticipation of an expected pain level can also influence the degree to which pain is experienced in a positive manner. In some cases, when the anticipatory level of pain expectation is lowered, the brain responds by influencing special neurons. This renders the brain less responsive to an incoming pain signal. Herein lies the rationale for biofeedback and meditation as pain control methods. In any event, both ascending (pain signals coming from the point of injury to the brain) and descending nerve pathways (signals from the brain to the point of injury) will influence or modify the effects of pain on the body (Grinstead, 2002).

Where psychological treatment fits in

Psychological treatment for chronic pain is used 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 does not mean that the patient's pain is imaginary. Psychological treatment goals are designed to help patients learn how to understand, predict, and manage their pain cycles, as well as use coping skills to minimize pain, and to maximize active involvement in positive life experiences in spite of the presence of chronic pain (Caudill, 2002; Sarno, 1998).

Additionally, psychological treatment for chronic pain focuses on the emotional toll people experience living with pain on a daily basis. Important factors such as disability, financial stress, poor quality of life, or loss of work are also a part of the pain picture, and require psychological treatment to address all relevant issues. Effective treatment for chronic pain does not include magical interventions or quick fixes; rather, it is a combination of proven psychological treatment approaches in addition to medication management and other non-pharmacological interventions (e.g., hydrotherapy, acupuncture, yoga, Tai Chi, diet/nutrition, stretching, biofeedback) that address all the problems people in chronic pain experience (Grinstead, 2002; Caudill, 2002; Sarno, 1998).

Looking at treatment outcomes

Determining the effectiveness of chemical dependency treatment is usually relatively straightforward, in a manner of speaking. If someone remains abstinent from alcohol and other psychoactive drugs, the treatment is deemed successful. Determining the outcome of treatment for chronic pain and a coexisting addictive disorder is much more complex.

It's not enough for patients to achieve abstinence from inappropriate medication. Effective treatment for someone with an addictive disorder and chronic pain requires a three part approach:

- (1) a medication management plan — in consultation with an addiction medicine specialist;
- (2) a cognitive-behavioral treatment plan — addressing pain versus suffering and changing behaviors; and
- (3) a non-pharmacological pain management plan — developing safer drug-free ways to manage pain (Grinstead, 2002, & Stimmel, 1997).

Recovery and avoiding relapse is possible if someone is willing to do the footwork and follow this plan using a collaborative multi-disciplinary treatment team (Grinstead & Gorski, 1999, 1997).

With the proper treatment plan and support, patients with chronic pain and coexisting disorders can have successful treatment outcomes. They can move from being a passive recipient (i.e., victim) to being an active participant in their healing process, leading them to once again feeling empowered and experiencing a higher quality of life once again.