Grinstead Treatment & Training

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Walking The Tightrope of Pain Management & Addiction

Walking the Tightrope Of Pain Management And Addiction

Using the Addiction-Free Pain Management® (APM) System

Developed By:

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The Development of APM™

- (1980-2011) My recovery experience – A journey of hope
- (1983-2011) Working with addicted pain patients
- (1986-20111) Applying the CENAPS® Biopsychosocial model to pain management
- (1996-2011) Field testing the system
  - Evaluating protocols that make a difference

The Development of APM™

- (1997-2011) Transferring the technology
  - The evolution continues with you and agency's like yours who utilize APM™
- (2006-2011) Addiction-Free Pain Management® Centers of Excellence
- (2011) *Freedom from Suffering: A Journey of Hope*
- *(2012) Freedom from Suffering Live*

Question One

Are We Managing Pain?

But Fueling Addiction?

Adapted from *Managing Pain & Coexisting Disorders: Using the Addiction-Free Pain Management® Treatment System.* 4200 North Freeway Ste. #3 Sacramento, CA 95834

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Question Two

Or, Are We Treating The Addiction

But Sabotaging The Pain Management?

Question Three

Is It Addiction?

Or Pseudoaddiction?

Background Information

- In 2004, 11 million used opiates non-medically
- Pain management patients with opiate abuse
  - 9% in this study to 41% in other research
- Pain management patients' with illicit drug use
  - 16% in this study to 34% in other research
- 90% of pain patients use opiates

Source: Pain Physician Journal, 2006; Volume 9: pp 215-226

Background Information

- Increase in opioid abuse from 2002 – 2007
- 2007 study of non-medical Rx opioid use
  - 56.5% of abused Rx given by friend r family
  - 18.1% came from only one doctor
  - 14.1% bought from friend or family
  - 4.1% came from drug dealer or stranger

Source: International Association For The Study Of Pain, 2009

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Cost of Pain Related Conditions

CONDITION	ANNUAL DIRECT MEDICAL COST	ANNUAL PRODUCTIVITY COST
Carpal Tunnel	$1 Billion	> $17 Billion
Lower Back	$25 Billion	> $28 Billion
Migraine	$1 Billion	> $13 Billion
Osteoarthritis	$25 Billion	> $8.3 Billion

Health & Productivity Management – Vol. 2, No. 2, 2005

Cost of Chronic Pain Management

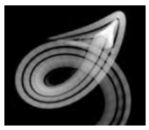
- Chronic pain is a major public health problem in U.S.
- Chronic pain management costs the nation an estimated $560 to $635 billion each year in medical treatment and lost productivity
  - This equals about $2,000 for everyone in the U.S.
- Chronic pain affects an estimated 116 million Americans
  - This is more than the number of Americans affected by heart disease, diabetes, and cancer combined

Source: Institute of Medicine (IOM) Report, June 29, 2011 — Relieving Pain in America

Treatment Outcome Indicators

High Outcome Patients

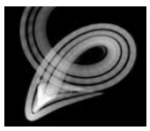
- Become actively involved in understanding their pain disorder and available treatment interventions
- Are open to multiple opinions & options
- Become self-motivated to actively & systematically experiment with both traditional & non-traditional pain management methods
- Positive Family and/or Social Support



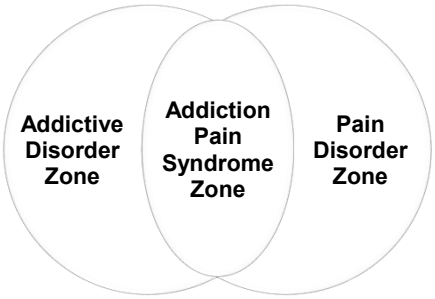
Treatment Outcome Indicators

Low Outcome Patients

- Become compliant in following recommendations with only the first professional they consult
- Expect to become pain free with minimal personal effort
- Are NOT motivated to experiment with both traditional & non-traditional pain management methods
- Lack of Positive Family and/or Social Support



Addiction-Pain Syndrome™



Non-Medical Prescription Drug Abuse

- ER visits for Opioid analgesics increased 111%, from 144,600 in 2004 to 305,900 in 2008.
- Most commonly used pain killers were Oxycodone (this includes OxyContin), Hydrocodone, and Methadone, all of which increased during the five-year period.
- ER visits for benzodiazepines increased 89% during the period from 143,500 in 2004 to 271,700 visits in 2008 and 24% during 2007 to 2008.

Source: U. S. Center for Disease Control – June 2010

Opioid Drug Overdoses Lead The Rest

- Of the 38,329 drug overdose deaths in the U.S. in 2010, about 58% involved pharmaceuticals.
- The most common pharmaceutical ODs were:
  - Opioids 75.2%
  - Benzodiazepines 29.4%
  - Antidepressants 17.6%
  - Anti-epileptic and anti-parkinsonism drugs (7.8%)

Source: JAMA 2013; 309: 657-659

Opioids Also Present In These ODs

- 77.2% of benzodiazepines
- 65.5% of anti-epileptic and anti-parkinsonism drugs
- 58% of antipsychotic and neuroleptic drugs
- 57.6% of antidepressants
- 56.5% other analgesics, anti-pyretics, & anti-rheumatics
- 54.2% of other psychotropic drugs

Source: JAMA 2013; 309: 657-659

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Commonly Abused Pain Drugs

- Alcohol, Marijuana, Methamphetamine
- Hydrocodone (Vicodin, Loratab, etc.)
- OxyContin & Oxycodone
- Demerol & Dilaudid
  - **Exalgo™ (Hydromorphone HCl) Remember Palladone?**
    24 Hour Extended-Release Tablets
- Opana (oxymorphone)
  12 Hour Extended-Release Tablets
- Morphine & Codeine
- Methadone

Commonly Abused Pain Drugs

- New generation of sleep medication
  - Ambien, Lunesta
- Supposed "non-addictive" pain medication
  - Ultram/Tramadol
  - Soma
- Benzodiazepines
- Over-The-Counter (OTC) Medications
  - Beware of acetometaphine
  - Beware of ephedra & alcohol

Patient Goals for APM™ Treatment

- Increase effective medication management
  - Reduce relapse rates
- Increase problem solving ability for better pain management solutions
  - Experiment with new pain management strategies
  - Increase level of functioning
  - Increase hope for recovery
- Reduce pain and suffering
  - Shift from victimized to empowered

Treatment Obstacles

- Failure to recognize coexisting disorders
- Family system problems
  - Codependency (or enabling behaviors)
  - Burn out & becoming angry with the patient
- Judgmental healthcare providers
  - Minimize the seriousness of their pain
  - Imply that "it's all in their head"
  - Blaming them - "they did it to themselves"
  - Accuse them of med/drug seeking behaviors

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Treatment Obstacles

- Patients' self-defeating reactions
  - Malicious compliance to keep Rx coming
  - Shift toward hopeless & helpless state of mind
  - Grief/Loss & feeling ashamed/guilty
  - Depression and other co-existing disorders
  - Treatment resistance and denial
  - Power struggles with treatment providers

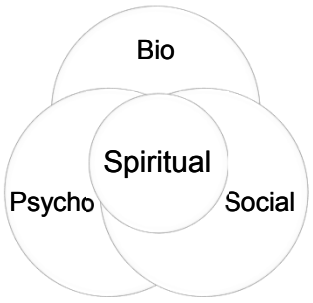
Expectations!

- Addiction Counselors
  - Abstinence Is "The Solution"
- Mental Health Providers
  - Psychotherapy Is "The Solution"
- Pain Management Providers
  - Medication Is "The Solution"
- Family Members
  - Please Just Fix My Loved One!

Looking At The Whole Person

- Axis I: Pain Disorder
- Axis I: Substance Use Disorder
- Other Axis I or II Disorders
- Axis III: Medical Condition(s)
  - Unsuccessful Medical Treatment
- Axis IV: Psychosocial Problems
- Axis V: Functioning And/Or Quality Of Life
  - GAF (Global Assessment of Functioning)
  - SOFA (Social & Occupational Functioning Assessment)
  - GARF (Global Assessment of Relationship Functioning)

Collaboration – Working With The Whole Person



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Common Co-occurring Disorders

- **Addiction & Chronic Pain Disorders**
- **Severe Sleep Disorder**
- **Cognitive Impairment**
- **Anxiety Disorders**
- **Trauma Disorders (PTSD)**
- **Depression**
- **Eating Disorders**

Overcoming Obstacles

- For Healing To Occur Patients Must Be . . .
  - Listened To
  - Understood
  - Taken Seriously
  - Affirmed As A Human Being

  Active Listening
- The Formula For Success
  - Using Effective Active Listening

Formula For Success

A Rational, Directive, Supportive Approach

Disaster	Success
~~Pre-Judgment~~	Understanding
+ ~~Insensitivity~~	+ Compassion
+ ~~Confrontation~~	+ Challenge
~~Power Struggle~~	Collaboration

Patients Must Be Proactive

- **Patients Become Knowledgeable Active Participants — Not Passive Recipients**
- The Patient Is **Always** The Captain Of The Team
- Healthcare Professional: Is A Guide Or Coach
- Use A Collaborative Non-Confronting Approach
- Create A Collaborative Treatment Plan
- Develop Recovery & Relapse Prevention Plans

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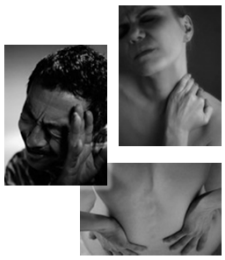
Types of Pain

- Acute Pain
- Chronic Pain
- Recurrent Acute Pain
- Anticipatory Pain
- Neuropathic Pain

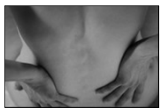


Acute Pain

- Symptom of underlying problem
- Damage to the system
- Source is easily identified
- Time limited healing process
- Analgesics or narcotics *may* be used

Chronic Pain

- Six month duration
- Source is often ambiguous
- Pain lingers long after initial injury
- May no longer serve useful purpose
- Treatment is often confusing and frustrating for patients and their healthcare providers



Recurrent Acute Pain or Pain Flare-Ups

- Patients experience acute pain episodes
- Episodes are usually brief
- Low or pain free periods between episodes
- Often associated with identifiable precursors
- Needs a separate treatment plan
- Most of the time the intervention can be non-medication based except for some serious pain condition i.e., cancer

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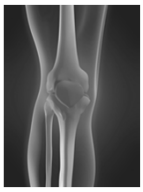
Anticipatory Pain

- Patients become so fearful about conducting basic tasks of daily living that they can become stressed or immobilized
- Activated by
  - Environmental triggers
  - Internal psychological/emotional triggers
- Often associated with previous pain episodes
- You get what you expect!

Neuropathic Pain

- Definition:
  - "Neural (nerve) dysfunction that persists beyond the normal time-period of tissue healing“



Neuropathic Pain

- Symptoms:
  - Tingling, itching, numbness (Parasthesias)
  - Shooting, burning, stabbing, aching, electrical sensations (Dysesthesias)
  - Non-harmful stimulus perceived as painful (Allodynia)
  - Spatial Changes: pain perception extending beyond initial area of tissue injury
- Phantom limb pain

Three Components Of Pain

- Biological
  - A signal that something is wrong
- Psychological
  - Meaning individual assigns to pain signal
- Social/Cultural
  - Role assigned to the person in pain
  - Family & cultural beliefs about pain

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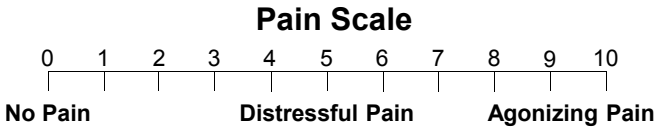
Pain Versus Suffering

- Pain — Physical sensations that tell us something is wrong
- Suffering — Psychological interpretation that the sensation is awful, terrible, or unbearable
- Pain is inevitable, but suffering is optional
- Freedom From Suffering
  - It's Your Right and Your Responsibility

Stress And Chronic Pain

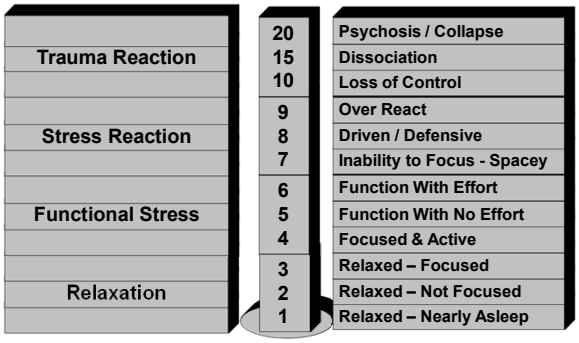
- Low Stress Zero To Three
- Moderate Stress Four To Six
- High Stress Seven To Ten



Levels of Pain

- 1 = Barely Noticeable
- 2 = Noticeable w/ No Distress
- 3 = Becoming Disturbing w/ No Distress
- 4 = Some Distress w/ No Coping Problems
- 5 = Distress w/ Some Coping Problems
- 6 = Distress w/ Significant Coping Problems
- 7 = Starting To Interfere w/ Functioning
- 8 = Moderate Interference w/ Functioning
- 9 = Severe Interference w/ Functioning
- 10 = Unable To Function At All

The Stress Thermometer



DSM IV-TR Pain Disorder

- Pain Is Predominant Focus Of Attention
- Pain Causes Significant Distress
- Psychological Factors Play Important Part
- Not Intentionally Produced Or Feigned
- Rule Out Being Caused By Other Disorders
- Specify Medical Versus Psychological

Understanding Addictive Disorders

Knowledge is Power

Stages of Rx Addictive Disorders

Seeking

Initial	Ongoing	Building	Abuse	Addiction
Experience	Exposure	Tolerance	Pseudo-Addiction	Death

Reaching

Misunderstood Terms

- Tolerance
- Physical Dependence
- Addiction
- Pseudo Addiction

Definitions 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)

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Tolerance

- 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.
- **Earth Language:** When you first used your medication it only took one or two pills to get relief and now it takes four or five.

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.
- **Earth Language:** When your body gets used to taking a medication on an ongoing basis and your brain adapts to that being the normal stat—then when you stop taking it suddenly you'll get sick or go into what is called withdrawal. For example a diabetic who is taking daily insulin then stops suddenly one day—they will get sick.

Addiction

- A primary, chronic, neurobiologic disease, with genetic, psychosocial, [spiritual] and environ-mental 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.
- **Earth Language:** When you are taking the medication for reasons other than physical pain relief and won't or can't stop taking it even when experiencing bad problems—then you're addicted to the medication.

Pseudo Addiction

- Behaviors that may occur when pain is not being adequately addressed. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch," and may otherwise seem inappropriately "drug seeking." Even behaviors such as illicit drug use and deception can occur in the patient's efforts to obtain relief.

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Addiction versus Pseudoaddiction

Earth Language:

- Pseudoaddiction looks a lot like addiction
- You may appear to be "Drug-Seeking"
- You may need frequent early refills
- These behaviors are caused by under-treatment or mistreatment
- Problematic behaviors disappear when your pain is adequately managed

Web Site Resources

- www.drstevegrinstead.com
- www.addiction-free.com
- www.cenaps.com
- www.chronicpainanonymous.org
- www.tgorski.com
- www.relapse.org

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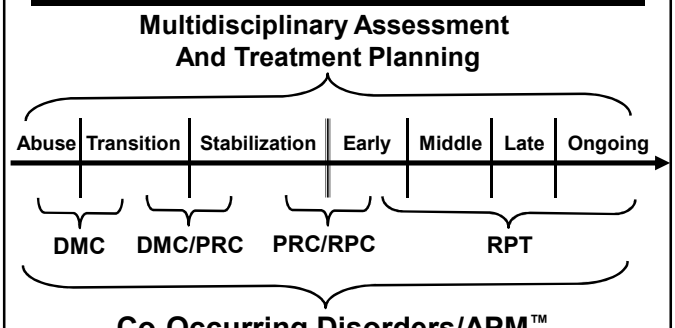
Developmental Model Of Recovery



What Is Your Definition Of Relapse?

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You Have To Be In Recovery To Relapse

What Is Early Recovery?

Being in recovery requires…

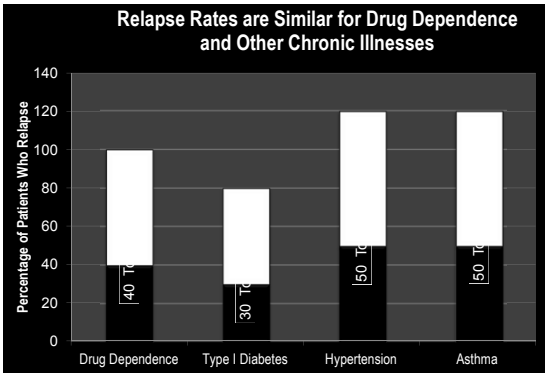
- ***Understanding*** the problem—pain and addiction
- ***Applying*** that understanding to self
- ***Accepting*** the painful feelings due to pain & addiction
- Having hope & belief recovery is possible & preferable
- Doing the B.P.S.S. recovery footwork recovery requires
- Building a medication management track record (90-120 Days)

Tools For Moving Into Early Recovery

- Moving from stabilization to early recovery requires…
  - Identifying and managing stress
  - Normalizing and managing cravings
  - Identifying and managing Post Acute Withdrawal
  - Managing Pain Flare Ups
  - Identifying and managing high risk situations

Relapse

- Like other chronic diseases, addiction often involves cycles of relapse and remission (ASAM 2011).
- Hypertension, asthma and diabetes have as high or higher cycle of relapse rates as addiction (ASAM 2011 & JAMA 2000).



Source: McLellan, A.T. et al., JAMA, Vol 284 (13), Oct. 4, 2000.

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Three Paths From Remission To Relapse

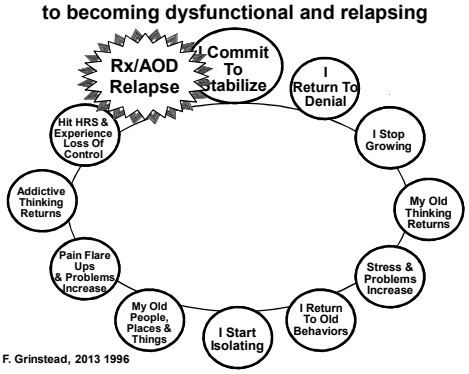
- Relapse triggered by exposure to addictive/rewarding drugs
- Relapse triggered by exposure to conditioned cues from the environment
- Relapse triggered by exposure to stressful experiences involves brain stress circuits

The anatomy and the physiology in these three modes of relapse have been delineated through extensive neuroscience research.

Source: American Society of Addiction Medicine, 2011 — http://www.asam.org

The Relapse Cycle

Moving from being stable in recovery to becoming dysfunctional and relapsing



What Is The Inner Saboteur?

Internal Conflict

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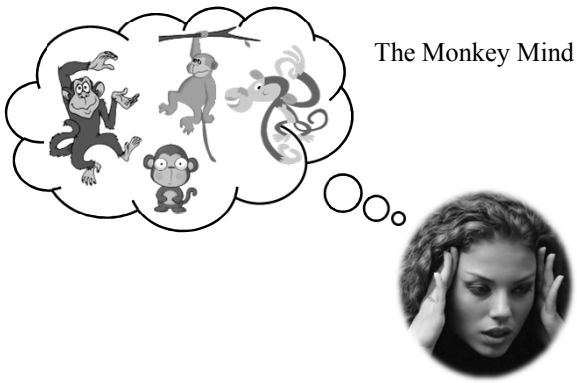

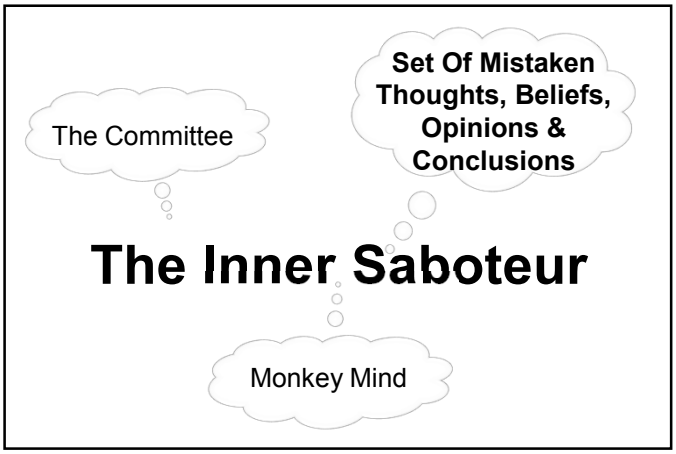

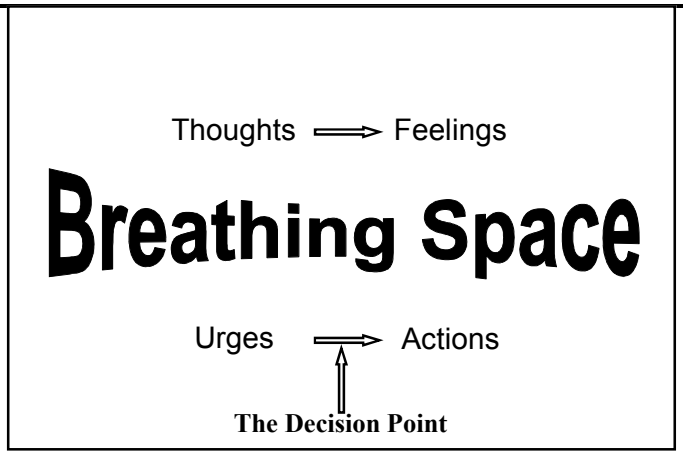

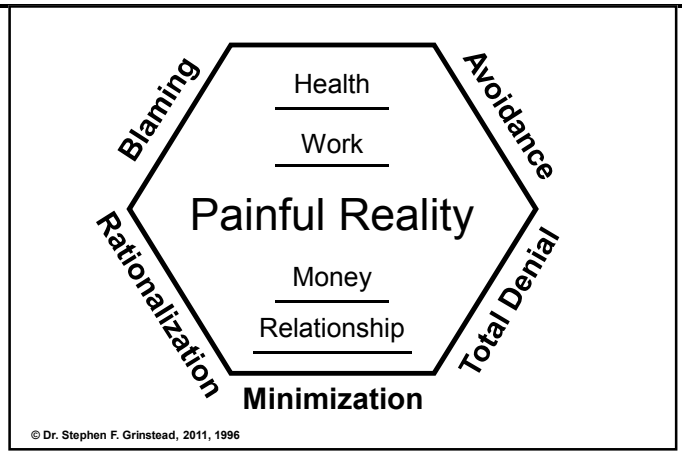

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Denial

Is an automatic & unconscious reaction
That operates as a defense
Against the pain of recognizing serious problems

It's A Normal Part of the Human Condition

Different Levels Of Denial

- Lack Of Information
  - Wrong information about addiction & pain
- Conscious Defensiveness
  - Know that something is wrong but don't want to face the pain of knowing
- Total Denial
  - Unconscious defense mechanism to guard against pain and helplessness
- Delusional
  - Deeply entrenched mistaken beliefs held in spite of overwhelming evidence to contrary

Big 5 Pain Denial Patterns

1. Avoidance:
   "I'll do anything to not talk about my pain management problem"
   - Types of Avoidance: Distraction, saying nothing, uproar, & playing dumb
2. Total Denial:
   - "No not me! I don't have a problem with pain!"
3. Minimizing:
   - "My pain is not that big of a deal!"

Big 5 Pain Denial Patterns

4. Blaming:
   "If I can prove that my problems with pain management aren't my fault, then I won't have to deal with them!"
5. Rationalizing:
   "If I can find good enough reasons for my problems with pain management, I won't have to deal with them!"

Small 7 Pain Denial Patterns

6. Comparing:
   "Showing that others are worse off than me proves that I don't have serious problem with my pain management!"
7. Compliance:
   "I'll pretend to give you what you want so you'll leave me alone!"
8. Manipulating:
   "I play the game to convince others to do all the work for my pain management."
9. Having A Flight Into Health:
   "Feeling better means that I'm cured!"

Small 7 Pain Denial Patterns

10. Fear of Change OR Recovery By Fear:
    "If I don't focus on having a problem with my pain I won't know how else to relate!"
11. Diagnosing Myself as Beyond Help:
    "Since nothing I do has ever worked for my pain management, I shouldn't have to try anymore."
12. I Have the Right to be This Way It's My Body:
    "I have the right to do whatever I want to do or don't want to do with my body and for my pain management and no one has the right to tell me different!"

The Antidote For Denial

- Peaceful Acceptance By
  - Staying centered while thinking about and talking about your problem
  - Calmly affirming the truth
- Honestly Affirm To Yourself That…
  - I have a serious problem!
  - I'm responsible for having it
  - I'm responsible for dealing with it
  - I'm willing to learn how

DMC Interactional Process

- **Identify**
  - Recognize Denial By It's Cognitive Theme
- **Expose**
  - Name The Denial Pattern & Cognitive Theme
- **Educate**
  - Explain The Denial Pattern Being Used
- **Challenge**
  - Give Permission To Stop Denying The Problem
- **Teach Self Management**
  - Show Another Way Of Thinking & Behaving

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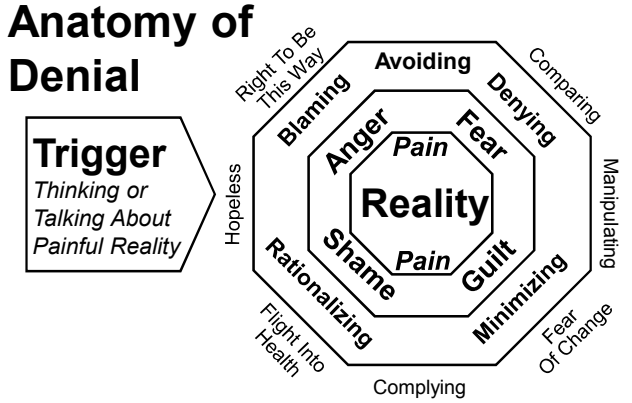
Anatomy of Denial



Making The Commitment To Stop Using Inappropriately

Current Problems	Relationship To Medication Use	Consequences Of More Use	Payoffs For Stopping
1. Problems Other People Want Me To Solve	Medication Use … 1. Caused The Problem 2. Made An Existing Problem Worse 3. Stopped Me From Solving The Problem **4. Helped Me Cope With The Problem**	1. Best	1. Worst
2. Problems I Want To Solve To Make My Life Better		2. Worst	2. Best
		3. Most Likely	3. Most Likely

1. What Do You Want Medication To Do For You?
2. Are You Getting What You Want? If So, At What Cost?
3. Are You Willing To Stop Using Inappropriate Meds Until You Complete Tx?

Looking For "Red Flags"

- Is your stress, depression, isolation increasing?
- Do you experience cravings or preoccupation with your pain medication?
- Are all medications being taken as prescribed?
- Is there a reduction in your non-pharmacological pain management interventions?
- Are you experiencing any negative consequences associated with your medication use?

Looking For "Red Flags"

- Are you honest with your support group about all medications, (including alcohol)?
- Do you use more than one prescriber for pain meds?
- Are you considering any elective medical or dental surgeries in the near future?
- Are you resistant to non-narcotic medications or referrals to non-medication pain management?

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Relapse With Rx Medication

- ***Elective*** Dental Procedures
- ***Elective*** Surgical Procedures
- Painful Injuries
- Painful Medical Conditions
- Mismanaged Chronic Pain
- What Are Examples Of What You've Seen?

Common Relapse Triggers

- Rushing Into Premature Elective Procedures
- Not Disclosing Recovery Status (Caution!)
- Ineffective Medication Management
  - Using the "wrong" type of medication
  - Large quantities or several refills
  - Using for psychological/emotional reasons
  - Holding & dispensing their own medication

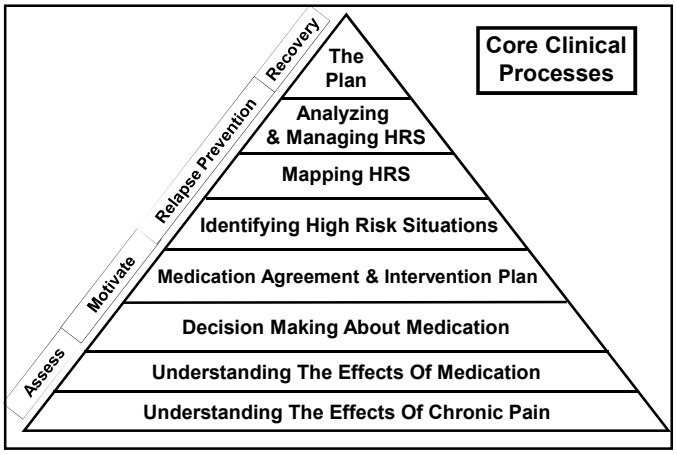
Comparing Treatment Models

- Pain clinics focus on the pain and struggle with co-existing addictive disorders
- Addiction programs focus on the addiction struggle with co-existing pain disorders
- APM™ focuses on the pain and addictive disorders concurrently
- APM™ works concurrently and synergistically with both conditions strategically and effectively

The APM™ System

- Core Clinical Processes
  - Using cognitive-behavioral-affective therapy
- Medication Management Components
  - Using effective medical interventions
- Non-Pharmacological Approaches
  - Using a proactive pain management approach

Walking The Tightrope of Pain Management & Addiction



Traditional Medication Management

- Opiate analgesics
- Opiate & non-opiate combinations
- Transdermal patches
- Benzodiazapines & muscle relaxants
- Non-Steroidal anti-inflammatory medications
- Antidepressant medications (Cymbalta)
- Anti-Seizure medication (Neurontin & Lyrica)

Recovery Friendly Medications

- Buprenorphine/Suboxone Methadone??
- Celebrex — Pre-Operation Loading 400mg
- All Other NSAIDS if side-effects tolerated
- Sleep Aids: Olanzepine 2.5mg (Zyprexa) and Ramelteon (Rozerem)
- Muscle Relaxants (Need to use caution with these)
  - Skelaxin® (metaxalone)
  - Zanaflex® (tizanidine hydrochloride)
  - Robaxin® (methocarbamol)
  - Flexeril® (cyclobenzaprine HCl)

Thank you Dr. Jerry Callaway & Sheila Thares

Recovery Friendly Medications

- Medications for neuropathic pain
  - Cymbalta® (duloxetine hydrochloride)
  - Lyrica (pregabalin) and Neurontin (gabapentin)
- Medications for migraines
  - Topamax® (topiramate)
  - Triptans (serotonin receptor agonists)
  - IV Toradol (ketorolac) for unresponsive pain
  - Zanaflex® (tizanidine hydrochloride)
  - Celebrex ® (celecoxib)

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Recovery Friendly Medications

- Ecotrin (coated aspirin — acetylsalicylic acid)
- Doxepin (Brand names: Adapin, Sinequan): Depression & Sleep
- Anticonvulsants
  - Tegretol® (carbamazepine)
  - Depakote (divalproex sodium)
- Elavil (amitriptyline)
- The recovery friendly patch/ointment delivery meds
  - Capsaicin
  - Lidocaine (Lidoderm)
  - The new nonsteroidal anti-inflammatory e.g., Voltaren

Thank you Dr. Jerry Callaway & Sheila Thares

Transitional Medical Procedures

- Spinal Cord Stimulation
- Lumbar Sympathetic Blocks
- Peripheral Nerve Injections
- Facet Joint Injections
- Epidural & Trigger Point Injections
- Nerve Blocks
- Radio Frequency (RF) Procedures

Non-Pharmacological Approaches

- Meditation And Relaxation
- Emotional Management
- Massage Therapy
- Physical Therapy
- Chiropractic Treatment
- Acupuncture
- Biofeedback
- Hypnosis/Self-Hypnosis

Other Non-Pharmacological

- Yoga/Tai Chi
- Diet/Nutrition
- Prayer
- Tribal Healing
- Sweat Lodges
- Talking Circles
- Pet Therapy
- Self-Help Groups
- TENS Units
- Reflexology
- Cranial Sacral
- Aerobics
- Rolfing/Hellar
- Nature
- Hobbies
- EMDR

Passive Versus Proactive Tools

Passive	Proactive
TENS/RS Stim Units	Practice Yoga/Tai Chi
DBT and CBT	Follow Diet/Nutrition Plan
Life Coaching	Practice Sleep Hygiene
Hydrotherapy	Participate In Aerobics
Rolfing/Hellar	Swimming Regularly
Physical Therapy	Frequent Nature Walks
Equine Therapy	Walking A Labyrinth
Hypnosis	Learn & Use Self-Hypnosis

APM™ Outcome Treatment Goals

- Decreased perception of pain & freedom from suffering
- Reduction or elimination of relapse episodes
- Increased levels of functioning & quality of life
- Develop effective non-pharmacological proactive pain management skills
- Resolve co-occurring psychological disorders
- Reintegrate with family, community and work
- Proactive relapse prevention plan
- Therapeutic continuing care & transition plans
- Shift from victimized to empowered

Final Call To Action

- Please answer these questions:
  - What is the most important thing that you learned today?
  - What are you going to do differently as a result of what you learned?
  - What could stop you from following through and how can you overcome any obstacles?

Web Site Resources

- www.drstevegrinstead.com
- www.addiction-free.com
- www.cenaps.com
- www.chronicpainanonymous.org
- www.tgorski.com
- www.relapse.org

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