Managing Chronic Pain in Patients with Substance Misuse / Addiction

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The Perfect Storm of Controversy

- Persistent Pain Hurts
  - Needless suffering
    - 100 million in U.S. with chronic pain
      - DM, HD, CA (combined)
    - 20-30% treated with opioids
  - >$600 billion/year in health care/disability

- Opioids Hurt
  - Opioid misuse and addiction disorder
    - 5 million non-medical users
    - $74 billion/year
    - "Gateway" drugs
      - Poisoning type
      - Overdose death
      - IOM, 2011; SAMHSA, 2011

From: Extramedical Use of Prescription Pain Relievers by Youth Aged 12 to 21 Years in the United States: Title and subTitle Break National Estimates by Age and by Year
Problems of Prescription Opioid Use

• 5 million non-medical Rx opioid users
  – 66% obtained medicine from family or friend
  – 80% obtained from a single prescriber
  – 75% “borrowed” drug instead of seeking healthcare
  – 69% used to control pain of common ailments
  – 35% “abused” or “dependent” on the drug

• Addiction, Misuse, Abuse, Something else?

SAMHSA, 2011; Boyd, et al. 2006; CASA, 2011

The Intersection of Pain and Problematic Opioid Use

• ~40% on Chronic Opioid Therapy (COT) have problematic drug-use behaviors
  – Aberrant Rx-taking behaviors / non-adherence
  – Fewer have prescription opioid misuse disorder
  – 2-5% have the disease of addiction

• Failure to identify concurrent pain/addiction
  – Undermines ability to treat either effectively

Webster & Webster, 2005; Gourlay, Heit & Almahrezi, 2005

Problem Yes … Epidemic … ?

• 15,000 Rx opioid deaths/yr
• Fatal single drug poisonings (2009 data)
  – 441 deaths from pain relievers with
    • 31% of them related to nonprescription analgesics
    • 60-80% of prescription opioids were obtained from
      non-medical sources or were not used as prescribed
    • Thus if 1 drug used 99% Rx opioids were non-lethal
    • Intentional vs. unintentional can’t be determined
  – Rise in Rx opioid deaths has leveled for 5 yrs

CDC, 2011; Poison Control Centers, 2009
Mistaken Beliefs / Unrealistic Fears?

- Patient is just “drug-seeking” to get high
  - Patients may be seeking relief
- Don’t want to cause an addiction
  - No single cause of addiction
- Don’t want to worsen addiction
  - Withholding treatment worsens all disorders
- Addicted patients can’t take opioids
  - Many can with proper dose/supervision

Persistent Pain

- Secondary Physical Problems
- Sleep Disturbance
- Rx Opioid Misuse
- Depression
- Anxiety
- Functional Disability
- Increased Stresses

Sleep Disturbance
Thus, addiction & chronic pain

- Are major public health concerns
- Involve changes in brain structure/function
- Carry a stigma that is a barrier to treatment
- Can be worsened by stress
- Are poorly understood
  - By friends, family,
  - By the health system & policymakers

Treating only one problem is a reason for relapse

- Treating pain but not depression fails
- Treating depression but not pain fails
- Treating pain not addiction fails
- Treating addiction not pain fails
- Growing appreciation for:
  - Link between comorbidities,
  - Psychosocial factors
  - Treatment failures

Addiction Refined Definition (ASAM 2012)

- Brain disease characterized
  - Inability to consistently Abstain,
  - Impaired Behavioral control,
  - Craving,
  - Diminished recognition of significant problems with one’s behaviors and interpersonal relationships
  - Dysfunctional emotional response.
**Ethical Rx of Pain & Addiction**

- Beneficence vs. non-maleficence
- Paternalism vs. autonomy
- Justice and respect for persons
- Declaration of Montreal
  - Recognizes the intrinsic dignity of all persons
  - Withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful…

IASP (2010); ASPMN (2002) revision expected 2012

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**Opioids can be used for chronic pain patients with addiction**

- Never the only treatment
- Expanded treatment team needed (where available)
- Dosed to prevent severe abstinence syndrome
- Part of multimodal therapy
  - Drugs with different actions, Side-effect burden/toxicity
  - Consider individual vulnerabilities
  - Nondrug therapies
    - Detox, initiate and maintain the recovery process
    - Improve functioning, coping and self efficacy

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**When Patients have Addiction and Pain**

**Judge the Treatment, Not the Patient!**

**DETERMINE …**
- Do the benefits outweigh the risks to the patient and society?
- Is functioning affected?
  - Better or worse with med?
    - Physical
    - Mental
    - Social

**NOT …**
- Is the Patient good or bad?
- Does the patient deserve meds?
- Should the patient be punished or rewarded?
Goals of Therapeutic Encounters

- Develop & maintain therapeutic relationship
  - Based on mutual honesty and respect
  - Avoid “lost to follow-up” or “discharged”
- Gain control of pain and drug use
- Harm reduction
- Help patients think, feel, and do better!

Motivational Strategies

- Motivational Interviews
  - Express Empathy
  - Develop Discrepancy
  - Roll with Resistance
  - Support developing Self-efficacy
- Motivational Incentives
  - Reduces pain-related avoidance behavior
  - Improves addiction treatment adherence
  - Counselors not fond of monetary rewards

Getting Foundation of Motivators

- Open ended questions re: drug/ nondrug Rx
  - Good things about opioid use?
  - Down side of opioids?
- Affirmation of strengths
- Reflection of core values
  - ...what would you be doing a year from now?
- Summary

Tailor focus to Stage of Change

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PRECONTEMPLATION

- Denies (or be unaware) of need to change
- Reluctant to discuss problem
- Others identify the problem
- Reacts when pressured or pursued
- Increased risk for argument

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Strategies for Precontemplation

- Establish rapport / basic trust
- Ask permission to get more information
- Raise doubts/concerns about opioid use
  - e.g. Physical, psychosocial, legal
- Goals:
  - Consciousness raising
  - Emotional arousal
### Contemplation
**Stage Strategies**
- Normalizes ambivalence
- Helps patient “tip” the decisional balance toward change
- **SMART GOALS:**
  - Specific: Significant, Simple
  - Measurable: Motivational, Manageable
  - Attainable: Achievable, Actionable, Acceptable
  - Realistic: Relevant, Results oriented
  - Timely: Trackable, Time-specific

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### Determination
**Stage Strategies**
- Admits & understands that change is necessary
- Initiates commitment to specifics
  - Goals, strategies, and target dates
- Begins to picture overcoming obstacles
- May procrastinate about actual start date

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<table>
<thead>
<tr>
<th>CONTEMPLATION</th>
<th>(best time for Motivational Interview)</th>
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<tbody>
<tr>
<td>• Demonstrates willingness to discuss, read and consider the problem</td>
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<tr>
<td>• Considers pros and cons</td>
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<tr>
<td>• Still has ambivalence and attempts action</td>
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<tr>
<td>• Can be obsessive about the problem</td>
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<tr>
<td>• Obsessiveness may prolong this stage</td>
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STRATEGIES FOR PREPARATION STAGE

• Clarify goals and strategies for change
• Offer variety of options for change & treatment
• Identify & plan to overcome barriers to change
• Elicit what has worked in the past
• Assist with issues / barriers:
  – Finances, transportation, child care, work
  – Other potential barriers

CBT as a treatment strategy

• Change mindset
  – Pain/craving is bearable
  – Can be resourceful and creative
  – Need to take action to solve problems
• Monitor & recognize behavior patterns
  – Thoughts, feelings & actions are linked

CBT treatment goals

• Teach timely adaptive coping
• Practice and master skills
• Positive reinforcement for efforts
• Rehearse / plan for future use of skills
• Plan for relapse prevention/management
  – Slips and falls

Cognitive-Behavioral Interventions

- Patient education
- Coping skills training
- Reframing, cognitive reappraisal
- Relaxation, imagery, hypnosis, biofeedback
- Pacing activities, exercise
- Structured support
- Caring presence

Perceptions to Challenge

- Half-truths / Self-defeating thoughts
- Mind-reading / Fortune-telling
- Exaggerated thinking, catastrophizing
- Pessimistic, hopeless / helpless thoughts
- Blaming a single person / event
- Self-pity … why me?! …. 
- Things can be the same … if only …. 

Perceptions to validate

- Your chronic pain, substance misuse and/or addictive disease are real problems
- You are responsible for participating in your pain...
- You can cope
- You did the best you could do at that time … can you learn to do better?
Key to successful CBT: Enhancing Self Efficacy

- Skill mastery
- Knowledge about sensory experience
- Lower arousal
- Sharing vicarious experiences
- Verbal persuasion


ACTION

- Behavior change as planned
- Tracks the behavior being changed
- Commits to identify / overcome obstacles
- Vulnerable to abandoning plan with impulsive actions
  - Insight is valuable for future work / change

Strategies for Action Stage

- Engage patient in treatment
  - Reinforce importance of recovery
- Support realistic view of change (baby steps)
- Acknowledge difficulties in early stage of change
- Help identify new reinforcers of positive change
- Scheduled follow-up (written/electronic homework)
Acceptance & Commitment Therapy

- Pain &/or suffering is a normal part of life
- Stop fighting to get rid of pain
- Don’t do the things that make it worse
- Types of pain can be distinguished
- Pain ~ mandatory, but suffering is optional


ACT: Experience Thoughts & Feelings

- Detect
  – Know a thought or feeling is present
- Register
  – Understand the message / experience
- Believe / heed
  – Take the experience as true
- Accept it without judgment
  – Be here and now … do the best you can

ACT: How it differs?

- CBT focuses more on thought than action
- ACT focuses more on the behavior / actions
  – ACT may explore the values and how thoughts keep the person “stuck”
  – Focus is the actions … being the best you can be
- CBT may be past or future focused
  – ACT is present focused
"I think that..."  "I’m having the thought that..."  "I notice I’m having the thought that..."

**MAINTENANCE STAGE**

- Accomplished change through focused efforts
- Varying levels of long term vigilance
- May be “losing” ground
  - due to slips
  - decreasing focus toward commitment
- Lifestyle change – enhance relapse possibility

**Strategies for Maintenance Stage**

- Assist in identifying and utilizing drug-free sources of pleasure / comfort (new reinforcers)
- Support continued lifestyle changes
- Affirm resolve & Self-efficacy
- Develop a relapse plan
- Review long-term goals
Relapse: A Real Concern

- Of concern to both patient & caregivers
- Risk factors:
  - Drug exposure
  - Unrelieved pain
  - Anxiety
  - Interactions with professionals that negatively impact self-image
  - Lack of a support system that can respond to need
- Collaborate with patient to develop a “relapse plan” ahead of time

(Volkow, NIDA, 2007)

RELAPSE IS A REALITY IN CHRONIC ILLNESS

<table>
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<th>Percentage of Patients Who Relapsed</th>
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<tr>
<td>Drug Addiction (40-60%)</td>
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<tr>
<td>Type 1 Diabetes (60-70%)</td>
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<tr>
<td>Hypertension (50-70%)</td>
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<tr>
<td>Asthma (50-70%)</td>
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STRATEGIES FOR RELAPSE

- Assist in re-entry to change cycle
- Commend willingness to reconsider positive change
- Relapse as a learning opportunity
  - Examine meaning and triggers
- Assist in developing coping strategies
Thank you!

Please save the date for our next webinar!

**Wednesday, June 27, 2012 12:00-1:00pm CT**

**Topic:** Adolescent Case Management: Pain and Opioids

**Speaker:** Helen N. Turner, DNP, RN-BC, PCNS-BC, FAAN - Clinical Nurse Specialist, Assistant Professor; Pediatric Pain Management Center; Doernbecher Children’s Hospital; Oregon Health & Science University; Portland, Oregon

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