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ADDICTIVE DISORDERS

MANAGING PAIN MEDICATION IN RECOVERY[1]

SUMMARY

An examination of addiction-free pain management, including effective treatment for chronic pain and substance abuse disorders.

ARTICLE

Patients with chronic pain who develop substance use disorders due to taking medication present a difficult challenge to treatment professionals. Many health care providers see no difference in treatment outcomes when these patients are treated either in a pain clinic for their chronic pain condition or at a chemical dependency treatment center for their addiction issues. In either case the prognosis ranges from poor to fair at best. However, it is possible to increase the probability of a more successful treatment outcome by creatively combining existing chemical dependency and chronic pain treatment methods using a multidimensional, non-traditional approach. For the purpose of this course, this treatment modality will be referred to as the Addiction-Free Pain Management (APM) System.

The APM system is a treatment approach that uses a biopsychosocial model to integrate the most advanced pain management methods developed at the nation's leading pain clinics, with the most effective treatment methods for addictive disorders developed at the nation's leading chemical dependency treatment programs. The result is a unique integration of treatment methods that combine proper medication management with non-medical techniques to insure both chronic pain management and addiction treatment. This leads to relief of pain while lowering or eliminating the risk of addiction or relapse.

For patients who are both chemically dependent and suffer from chronic pain—hereon referred to as APM patients—there are significant obstacles to be addressed before positive treatment outcomes can be realized. Unfortunately, there is a critical shortage of documented research and studies pertaining to this particular population. As a result, many physicians prescribe addictive drugs to patients with chronic pain without taking necessary precautions. This is due in part to the fact that there are so few treatment alternatives proven to be effective. However, there have been cases of successful treatment with this population that can be studied and verified. Treatment methods that have proven successful must be tested further in controlled longitudinal studies to ensure their reliability, validity, and lasting effects.

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LITERATURE REVIEW

A significant amount of literature can be found concerning chronic pain treatment, as well as chemical dependency (CD) treatment. However, there is a paucity of information concerning concurrent treatment of both disorders. Therefore, this literature review will focus primarily on chronic pain treatment and moderately on CD treatment in order to get as definitive a perspective as possible. The intent will be to show the strengths and weaknesses of each treatment modality while explaining how combining treatments could facilitate a more positive treatment outcome. This comprehensive analysis is required in order to gain a more thorough understanding of the complexities and special treatment interventions necessary to improve the prognosis for this APM population.

Identification and assessments. The initial interview with an APM candidate is probably one of the most crucial points in the treatment process. An accurate identification and assessment is extremely important in all cases but even more consequential when a patient is chemically dependent and has chronic pain. Unfortunately, this type of patient does not get the necessary comprehensive assessment at either a chronic pain clinic or a chemical dependency treatment center. The pain clinic will focus on and identify the Axis III physical disorders while the CD center will assess for the presence and severity of the chemical dependency. In addition, a third concern, coexisting disorders (Axis I Mental Disorders and Axis II Personality Disorders), are not adequately addressed by either treatment provider.

Another issue that is problematic concerns patients being rejected by pain clinics when chemical dependency or psychopathology is suspect. Corey, Linssen, and Spinhoven (1992) found that seven out of twelve programs they reviewed rejected patients with psychiatric problems. In another study, Deardorff, Rubin, and Scott (1991) rejected patients with a drug-abuse problem or exhibiting signs of a psychological disorder as inappropriate for treatment.

This contrasts with the pain patient in a CD treatment center who is labeled as drug seeking and in denial when asking for medication for pain reduction. Many of these patients are administratively discharged and told: “go take care of the pain problem and then come back.” Rogers and McMillin (1989) believe that addiction treatment groups should be homogeneous by diagnosis. Therefore, both dual diagnosis patients and chronic pain sufferers would be considered inappropriate for their groups.

However, an APM program can deal with all of those dynamics successfully, since this modality addresses pain, chemical dependency, and psychological issues simultaneously. One way of accomplishing this goal is to follow the lead of Brown (1989) who promotes the importance and use of appropriate techniques for evaluating the presence and degree of chemical dependency. She describes the process of exploring the physical, behavioral, social, cognitive, and psychological history of the person undergoing treatment to gain an accurate picture of the presence, degree, and impact of the chemical dependency and other problem areas.

With chronic pain patients there is usually some underlying psychopathology. Therefore, the assessment procedures must be sensitive to the signs and symptoms of Axis I mental disorders and Axis II developmental and personality disorders. Kennedy & Crowley (1990) discovered that their entire test group of chemically dependent chronic pain patients met diagnostic requirements for other another Axis I or II diagnosis. “In terms of problems and pitfalls, we were quite surprised at the severity of the psychopathology seen in all of these patients apart from their drug abuse.” In his treatment of APM patients Mac (1998) has also observed similar conditions in most of the cases he has treated. In fact, he considered it a rare occurrence if an APM patient did not exhibit signs and symptoms of a dual diagnosis.

Early treatment approaches. Another major philosophical difference between pain clinics and CD treatment centers concerns medication and detoxification issues. Although many pain clinics do withdraw their patients from most narcotic medication, some do not.

Halpern and Robinson (1986) discussed a study where chronic pain patients who had failed to respond to a variety of pain management strategies were placed on narcotic maintenance. Most of them were then able to return to work. However, follow-up was not completed to determine the lasting effectiveness, nor whether the patients experienced negative consequences of prolonged use of a narcotic.

Like most CD treatment professionals, Gorski (1989, 2000) recognizes that chemical dependency is a chronic disease that, if left untreated, is terminal. Therefore, he believes that the removal of all psychoactive chemicals is imperative for effective treatment. This total abstinence may not be a realistic solution for some chronic pain conditions and other measures must be taken, which will be discussed in a future paper.

In CD treatment centers there are basically two methods typically used for administering detox medication: (a) on an as needed (PRN) basis and (b) a regular interval administration. One drawback of the PRN method usually results in the patient experiencing high levels of pain before each dose. Although physician prescription of analgesic in sufficient doses may be preferable, a compromise solution would consist of a PRN order with a range of doses. "The patient would then be asked at each specified interval if pain relief is needed and, if so, whether the pain is severe enough to warrant the larger dose. This allows for both patient control of symptom relief as well as appropriate flexibility in dosage due to fluctuation in pain intensity" (Stimmel, 1983, p. 248).

Corey and Solomon (1989) oppose as needed medication and suggest other alternatives. "The first problem with taking painkillers 'as needed' is that most people wait and medicate themselves only when their discomfort levels are at their highest. It then takes a while for the drugs to enter the bloodstream and affect the pain system" (p. 166). Two other reasons given for their bias is the possibility of worsening the addiction and the lack of preventative action taken by the patient. They go on to discuss a three-step approach that includes patient self-monitoring, a fixed time schedule, and reducing the dosage with the complete elimination of medication as the ultimate goal whenever possible (pp. 166-71).

Many pain clinics use the pain cocktail procedure for detoxification of their patients (Corey, Linssen, & Spinhoven, 1992; Deardorff, Rubin, & Scott, 1991). This technique allows the gradual and systematic withdrawal of analgesics, narcotics or benzodiazepines. The process involves combining the detoxification medication into a single mix, which is given in a disguising mixture (such as cherry syrup). The mix is given only at fixed time intervals on an ongoing basis. The decrease in medication is achieved by gradually withdrawing the active ingredients, while keeping the total volume the same.

One difficulty with the pain cocktail approach is that it keeps the patient in a passive role. Mac (1998) contends that APM patients need to take a pro-active part in their treatment, which includes being informed about the exact parameters of their detox protocol. However, Linchitz (1987) contends that if patients knew when the dosage was being decreased and by how much they would experience a negative emotional reaction. Linchitz recommends utilizing a pain capsule that uses the same concept as the pain cocktail. He contends that patients with no knowledge of the dosage reductions show no adverse psychological reactions to the detox procedure. In addition, Linchitz also supports the fixed time concept (regular intervals) for administering the detox drugs instead of the PRN method.

Eclectic and non-traditional treatment approach. When patients are being detoxified in the pain clinic setting, they are also being exposed to new pain management modalities. Unfortunately, those modalities do not occur in CD treatment centers since pain management is not included in their treatment protocol. In fact, the patients who complain about their pain are usually seen as drug seeking. However, pain clinics also have their own shortcomings. Besides putting a patient in a passive role, most chronic pain treatments fall short because they lack a multidimensional approach. Corey and Solomon (1989) believe that most chronic pain

patients require an active, multidimensional approach to treatment; for example, a program of exercises, chiropractic treatment, cognitive-behavioral strategies and massage therapy.

When using massage therapy it is important to realize that there will be some immediate pain relief and reduced muscle tension, but it will be short-lived if not followed with other measures. This is understandable since there are many precursors or triggers for muscle tension that often resurface soon after the massage session. Therefore, other measures must be implemented that are specific to your needs, and used in the proper sequence. Some of the methods that are successful in resolving these other triggers are training the patients to use relaxation and meditation techniques, a customized exercise discipline, and the use of biofeedback.

Many treatment professionals believe it is important to use a combination of physical therapy and hydrotherapy to help patients learn how to strengthen and recondition their bodies, thus becoming active participants in their healing. Reilly (1993) agrees that hydrotherapy and a water-based exercise program can be an extremely helpful active modality for people with chronic pain. "One of the most beneficial ways for PWCPs (person with chronic pain) to exercise is in water. Water buoys the body. It takes the strain off body parts.... Walking in the water for twenty minutes has benefits equivalent to two hours of walking on land" (p. 58). Biofeedback has proven to be another effective active method that chronic pain patients can learn to further participate in their own treatment.

Devine (1988) discusses the condition of dysponesis, also called faulty bracing, where people tense up their muscles to pain which in turn intensifies the pain experience. "The most direct approach to decreasing faulty bracing is through the use of EMG biofeedback. This biofeedback modality involves the placement of electrodes directly over the affected muscles.... With proper training he or she is able to learn how to consciously let go of muscle tension" (p. 1). According to Jaffe (1986) an effective biofeedback training program should be progressive and include the following stages: "(1) A clear diagnosis and observation of the problem and its context in an individual's life, (2) Selecting a treatment strategy and modality, (3) Practicing the new skill, both in the clinic and at home, (4) Practicing the new skill in the specific situations in which most problems arise" (p. 207). Training the patient to use meditation and relaxation techniques to reduce stress would also be a useful complement to the biofeedback process. Wall and Jones (1991) believe that stress reduction practice, as well as other holistic approaches, combined with biofeedback, have proven to be an excellent way to reduce pain symptoms. They also discuss hypnosis and meditation as effective belief and attitude therapeutic approaches that have proved successful in treating chronic pain.

Most CD treatment professionals realize the importance of teaching their patients how to appropriately deal with emotional issues to reduce their stress and anxiety. In fact, Gorski (1989, 2000) believes that avoiding painful emotions will often lead a chemically dependent person to a return to denial followed by a chemical relapse. Unfortunately, many pain clinics do not focus on the emotional component. In their review of 32 multi-modal pain treatment programs, Corey, Linssen, and Spinhoven (1992) found many interventions and treatment approaches, however, no emotional modalities were being used.

Sarno (1991, 1998) believes that repressed emotions, especially anger, leads to a condition he calls Tension Myositis Syndrome (TMS). He states that it is important to stop repressing emotions and that psychological conditioning contributes to ongoing pain conditions.

Corey and Solomon (1989) devote an entire chapter of their book discussing chronic pain and emotions. They discuss the different treatment strategies needed to deal with emotions such as anger, depression and anxiety. Some of the methods include cognitive-behavioral therapy, exercise, meditation and relaxation. Roy (1992) is another advocate of the link between chronic pain and emotions. Roy also believes in many cases, especially when there is clear and unambiguous evidence of suppressed or repressed emotional issues, that dynamic

psychotherapy is an effective treatment modality. Cleveland (1988) maintains that dealing with the emotional component of chronic pain is an extremely effective treatment approach. Cleveland adapts and incorporates the 12-Steps of Alcoholics Anonymous by showing people with chronic pain issues how to improve the quality of their lives and deal with their emotions.

Dealing with emotions and promoting faster healing can be facilitated through the use of meditation. Coffey-Lewis (1982) describes how the practice of meditation leads to true and lasting healing. Coffey-Lewis discusses how meditation takes on many different definitions for different individuals. For some meditation is used for stress reduction; to others it is a scientific way of interconnecting parts of the brain; and still others find it helpful in healing the splits in personality and integrating wholeness. Cleveland (1988) also promotes the use of meditation for improving quality of life and for self-healing. Mediation is also a part of the 12-Step process—the Eleventh Step. Reilly (1993) analyzes Step Eleven by showing people with chronic pain how to apply it towards their healing process, and demonstrates how to use the meditation portion of that step.

One last alternative pain reduction procedure, acupuncture, needs to be briefly discussed. Corey and Solomon (1989) discuss the pros and cons of acupuncture. There have been some dramatic success stories regarding the complete disappearance of a pain condition.... Unfortunately, there are many people who experience either no relief after acupuncture treatments, or only transitory relief. Chronic-pain sufferers who do experience short-term relief may become regular acupuncture patients (p. 180). Of course the danger of becoming a frequent acupuncture patient is that the person could again take on a passive role in treatment, which is counterproductive to effective ongoing pain management.

Relapse prevention planning. Over the past decade, relapse prevention planning has become an important component in many CD treatment programs. Gorski (1990a, 2000) discusses the CENAPS© model of relapse prevention. This method includes relapse warning sign identification, warning sign management training, developing a relapse prevention network, and constructing an early intervention plan to be implemented if sufficient signs of relapse appear. Unfortunately, there was no literature discovered that showed pain clinics incorporating intensive biopsychosocial relapse prevention plans into their treatment programs.

Measuring treatment effectiveness. In chemical dependency treatment determining the effectiveness of treatment is relatively straightforward. If the person remains abstinent from alcohol and other psychoactive drugs, the treatment is deemed successful. Conversely, determining the outcome of chronic pain treatment is much more complex. Therefore, it is not enough for the chemically dependent chronic pain patients to achieve abstinence; they must also realize an improvement in their pain condition and quality of life. In order to determine which treatment modality is more effective, it is imperative to have a operational definition regarding what constitutes successful treatment. Unfortunately, there does not seem to be any consistency to the manner in which chronic pain clinics rate treatment success. Moreover, those programs cannot even verify that the treatment given was responsible for those improvements that were observed in their patients' conditions.

Deardorff, Rubin, and Scott (1991) address the problematic situation regarding relatively few outcome studies of chronic pain programs that utilized no-treatment comparison groups. Their study documents the importance of using a control group to validate treatment effectiveness. Furthermore, they argue that subjective patient self-reports of pain conditions are not reliable for validating treatment results. They recommend determining treatment success by placing the emphasis on observable objective changes in the level of day-to-day functioning. The results of their study supported the conclusion that comprehensive multidisciplinary pain treatment is effective in producing positive treatment outcomes. Those results are further validated because the control group, which received no treatment, failed to show similar favorable treatment outcomes.

Many pain clinics indulge in an over-reliance of mailed questionnaires and have poor follow-up response rates. Stacy, Kaplan, and Williams (1992) discuss the importance of highly structured in-depth follow-up evaluations to determine treatment success. They recommend a follow-up every few months and to be considered a treatment success, the positive results must last at least a year. Corey, Linssen, and Spinhoven's (1992) evaluation of the 32 multimodal pain center programs they reviewed concluded: "there is a lack of randomized control groups and reliable, non-retrospective (follow-up) data" (p. 283).

Addiction-Free Pain Management (APM) overview. Patients with a chronic pain and addiction diagnosis have specific needs that are different from the typical chemically dependent person or the person who suffers only from a chronic pain condition; therefore, a specialized APM approach needs to be formulated and implemented. In addition to the pain and chemical dependency screening, this approach assesses for the psychological issues present before chemical abuse, new psychological problems arising from the pain and subsequent addiction, as well as finding innovative treatment modalities for this particular population.

The introduction of new pain management techniques needs to be presented early in treatment—preferably during the detoxification stage. Including relapse prevention education is also an important component for any chemical dependency treatment modality. For individuals with the coexisting pain disorders, relapse prevention is even more critical.

Since the chronic pain and addiction condition is a multidimensional and complex problem, it is logical to assume that a multi-treatment modality must be applied to address this phenomenon. The first step in treatment is a complete medical examination that identifies and diagnoses the Axis III (physical) disorders and other conditions present in the patients. The treating physician needs to access any previous records from other doctors who are treating, or have treated, the patients. In addition, the APM physician needs to be addiction medicine certified with extensive expertise in chemical dependency treatment. During the physical examination the treating physician addresses the chronic pain condition as well as the medical impact chemical dependency has on the patient. At this point the doctor will also begin assessing the severity of the chemical dependency.

After the initial medical examination, the treating physician determines an appropriate detoxification and stabilization treatment plan that is implemented immediately. Appropriate detoxification medication is prescribed to control the discomfort and pain of withdrawal symptoms from the abused drug. Besides the pain of withdrawal, the APM patient can also experience an increased sensitivity to their chronic pain condition. To address the physiological pain issues non-narcotic and non-psychoactive medications are preferable, but for some conditions this is not always possible.

There are various schools of thought regarding the manner of administering the detoxification medication no matter which medication is prescribed. There are basically two methods typically used: (a) on an as needed (PRN) basis and (b) a regular interval administration. As discussed earlier, there are different philosophies about which method to use. However, neither the pain cocktail nor the pain capsule is recommended for APM patients. Any distress experienced by the patients regarding knowing their medication is being decreased becomes a treatment issue and specific treatment plans are implemented. Before deciding which detoxification protocol to implement, the individual patient's situation needs to be considered and discussed by the entire treatment team, including the patient, in order to reach the most therapeutic decision possible.

Another dynamic that complicates detoxification procedures is that the patients who are chemically dependent and have chronic pain are seeking both withdrawal symptom relief and chronic pain relief. For those reasons it is imperative to immediately begin educating patients regarding both the nature and progression of chemical dependency and introducing non-pharmacological pain management techniques.

The next phase of treatment is assessing the nature and degree of the chemical dependency, which is a treatment team responsibility. In conjunction with the physician's evaluation, the counseling (or psychotherapeutic) staff will also be conducting assessments using the tools of their own discipline. This stage can include Brown's (1989) process of exploring the physical, behavioral, social, cognitive, and psychological history of the person undergoing treatment to gain an accurate picture of the presence, degree, and impact of the chemical dependency. The results of all assessments, as well as any information from outside resources, are examined and discussed by the entire treatment team when all assessments have been completed.

In conjunction with a chemical dependency evaluation, a thorough biopsychosocial history is collected. Assessing this history is the first step in determining the presence and degree of any Axis I mental disorders or Axis II developmental and/or personality disorders as well as determining what, if any, impact the person's family of origin dynamics have on their present circumstances. However, one should not be too quick to finalize the diagnoses of any suspected disorders until the patient has been completely detoxified, as the effects of chemicals and the withdrawal process are similar to the signs and symptoms of many Axis I or Axis II disorders. However, as covered earlier, chronic pain patients typically do have some underlying psychopathology.

As family of origin issues may have an impact on a patient's response to treatment, it is important for the team to be aware of the patient's history. During a five-year period at a local chemical dependency treatment center that had an Addiction-Free Pain Management (APM) component, Mac (1998) discovered that 100 percent of the chronic pain patients treated there came from families with moderate to extreme dysfunction. In addition, the level of family dysfunction was often an indicator of the seriousness of the chronic pain and addiction—the more serious the dysfunction, the more serious the pain and addiction.

When suspicions arise about the possibility of an abusive family history, assessments are conducted using appropriate techniques. Ammerman and Hersen (1992) cover many current state-of-the-art assessment tools and procedures, giving clinicians a resource for examining the antecedents, impact, and consequences of family violence. When those situations are uncovered, members of the treatment team adequately trained in this discipline determine whether or not the problem can be postponed until after the in-patient portion of treatment. The patients receive emotional support from the team and a referral is provided for post-discharge treatment in that area. After evaluating and discussing each of the above assessments, the treatment team chooses and implements an appropriate treatment plan.

Once patients are actually in treatment and being detoxified, they are in what Gorski (1989, 2000) calls the Transitional Stage of Recovery. According to Gorski there are four important tasks that need to be accomplished during this stage: (a) physical recovery from the withdrawal effects of chemicals, (b) discontinuance of the preoccupation with chemicals, (c) learning to solve problems without using chemicals, and (d) developing hope and motivation for recovery. Brown's (1989) Transitional Stage in like manner includes four tasks: (a) surrender (hitting bottom), (b) forming of a new identity as an alcoholic and/or addict, (c) object substitution (discovering things to replace the addiction), and (d) relapse prevention strategies and abstinence skills. Furthermore, to give the APM patients the best hope of rapidly accomplishing these transitional tasks, they are quickly integrated into the treatment milieu.

Building trust and safety is important to help these patients bond and fit in. Many of them have learned not to trust as a result of their dysfunctional family systems, and have typically become very isolated by the time they enter treatment. Some patients have exhibited paranoid and/or agoraphobic symptoms. Assisting APM patients in letting go of their denial and other defenses through education and information, while at the same time helping them learn to trust others, enables them to become capable of admitting and accepting their chemical dependency.

They can then identify with others in the treatment program, which enables them to transition to recovery. Much of this process is accomplished using a combination of psychoeducation and group therapy followed up with individual sessions on an as needed basis.

Since part of this population's preoccupation with medication stems from a legitimate need for pain reduction, non-pharmacological pain treatment modalities are developed and put into place. An important goal in this phase of treatment is to begin empowering patients, relieving them of the passive role in dealing with their pain. A pro-active approach, including physical therapy and cognitive-behavioral strategies, is implemented.

Another approach that has proved successful is chiropractic treatment. Many chronic pain patients receive long-term pain reduction when undergoing chiropractic treatment. According to Dr. Martin, (1998) chiropractors who specialize in chronic pain treatment use chiropractic adjustments to increase the release of endorphins and remove existing nerve interference. Chiropractors also prescribe supplemental therapy in the form of vitamins and minerals which help build up the immune system while at the same time raising the patient's pain threshold.

When a need is indicated, natural muscle relaxing agents and anti-inflammatory medication that do not exhibit the negative consequences that usually occur with many of the traditional pharmaceutical preparations, are also prescribed for chronic pain patients. In addition, massage therapy will be prescribed when appropriate.

When using massage therapy it is important to realize that there will be some immediate pain relief and reduced muscle tension, but it will be short-lived if not followed-up with other measures. There are several triggers for muscle tension, including poor posture, stress, anxiety, and muscular habits. Some of the methods that are successful in resolving these triggers include training the patients to use relaxation and meditation techniques, a customized exercise discipline, and the use of biofeedback.

It is also important to use the combination of physical therapy and hydrotherapy to help patients learn how to strengthen and recondition their bodies, thereby becoming active participants in their healing. Biofeedback has proved to be another effective active method that chronic pain patients can learn to further participate in their own treatment.

There are many different methods of using biofeedback. Some of them require the use of expensive equipment and are not feasible for most APM applications. However, some equipment is used initially as training aids and for extensive practice. For this reason some biofeedback techniques are introduced during the inpatient phase of treatment and then intensive work continues on an outpatient basis.

Biofeedback is an effective treatment for the condition of dysponesis, also called faulty bracing, where people tense up their muscles to pain, which in turn intensifies the pain experience. Devine (1988) believes that the most direct approach to decreasing faulty bracing is through the use of EMG biofeedback. Training the patient to use meditation and relaxation techniques to reduce stress would also be a useful complement to the biofeedback process. Stress reduction practices, such as meditation and progressive relaxation techniques, combined with biofeedback have proven to be an excellent way to reduce pain symptoms.

One more alternative pain reduction procedure, acupuncture, is also prescribed when indicated. Many patients benefit from this procedure. On the other hand, there are cases of people who experience either no relief after acupuncture, or only transitory relief. Of course the danger of becoming a frequent acupuncture patient is that the person could again take on a passive role in treatment, which is counterproductive to effective ongoing pain management. There are many other alternative non-traditional pain management modalities that a well-trained treatment team can prescribe and implement as indicated by each patient's specific needs. All the chosen strategies then become an important part of the patient's relapse prevention plan.

Relapse prevention planning. Once the patient is stabilized and has progressed to the early stages of recovery, the next step of effective treatment is relapse prevention planning.

According to Gorski, (1990b, 2000) relapse prevention is a systematic method for teaching relapse-prone individuals how to recognize and manage their relapse warning signs. It is critical that the client (a) understand what chemical dependency is, (b) recognize that they are chemically dependent, and (c) be willing to accept their chemical dependency. This stage is even more important to the APM patient than is the case with a chemical dependency patient. Fortunately, the same relapse prevention planning process is used successfully when it is adapted to the unique needs of this population. Although many of the APM patients have never been in recovery, and therefore have not experienced a relapse, the entire process may not be the indicated treatment; however, since this population is definitely relapse-prone, many of the techniques developed by Gorski are certainly applicable.

It is important for the treatment team to make sure that the patient is motivated towards recovery before relapse prevention planning begins. "Motivated relapse-prone patients recognize that they are chemically dependent, need to maintain abstinence to recover, and need to maintain an ongoing recovery program to stay abstinent" (Gorski, 1990a, p. 126). Relapse prevention starts with the warning sign identification process. Gorski, (1990b) defines relapse warning signs as a progression of problems that are interrelated and causally connected, that result in addictive use, collapse, or suicide and are activated by either core-addictive or core-psychological issues. APM patients will also have core-pain issues to contend with.

Core addictive issues are "problems caused by the addiction itself that would not exist if the addiction had not developed. They create pain and dysfunction in recovery and require a recovery plan" (Gorski, 1990b). Denial is a prime example of a core addictive issue, and in the case of chronic pain patients, the denial is often much stronger. A typical APM patient might say, "I can't be a real addict because I have pain and the doctor gave me the meds."

The core-pain issues are problems caused by the chronic pain condition and the patient's response to the condition. An example of a core-pain issue might be the cyclical increase (flare-up) of pain due to the stresses of everyday living. Core-psychological issues are "repetitive problems caused by unfinished business from childhood or unresolved adult trauma. They create a deeply entrenched system of irrational beliefs and they coexist with the core-addictive issues" (Gorski, 1990b). Some common examples are post-traumatic stress disorder (PTSD) and Axis II personality disorders.

To increase effectiveness, treatment teams may include a Certified Relapse Prevention Specialist (CRPS) during this stage of treatment. Since many of the core issues have been identified during the assessment and treatment stages, this warning sign identification stage of treatment uncovers any other hidden issues, as well as warning signs that may have been missed during the previous stages. This warning sign identification process will continue after the patient is discharged from primary treatment and may take weeks, and in some cases months. Therefore, appropriate referrals are made while the patient is still in the treatment center.

As warning signs are identified, management skills and interventions are developed. It is also important to recognize and differentiate which warning signs are driven by core-addictive, core-psychological, and core-pain issues. Furthermore, the CRPS will start to identify and intervene on the patient's relapse justifications.

Relapse justifications are patterns of irrational thinking that create an immediate justification for chemical use. Gorski (1990b) discusses four common basic justifications: (a) euphoric recall (it worked in the past it must be OK now), (b) "awfullizing" sobriety (sobriety is and always will be terrible), (c) magical thinking (using chemicals will fix me), and (d) low tolerance for frustration (I can't stand feeling so bad). One of the most common relapse justifications for chronic pain patients is: "I have a legitimate reason to be in pain. Therefore, it's OK to do anything to stop my pain." It is critical to teach patients how to identify and talk

back to their relapse justifications and how to manage their warning signs. For effective warning sign management, a relapse prevention network is developed.

This relapse prevention network usually consists of the patient, the CRPS, family members and/or significant others, health care professionals, therapists, and appropriate 12-step support people (such as a Pills Anonymous sponsor). Health care professionals, therapists and 12-step support are put in place before the patient leaves primary treatment.

The patient works with this network to develop a relapse intervention plan. This is one more way chronic pain patients take an active role in their recovery process. They share their relapse warning signs with the network and inform each person in the network what they want each member of the network to do if they see any active warning signs and/or symptoms of chemical use. Identifying their early critical warning signs and sharing that knowledge with their relapse prevention network greatly increases the chances of stopping a relapse before the chemical use begins.

Evaluation of treatment outcomes. Determining the effectiveness of chemical dependency treatment is relatively straightforward. If the patient remains abstinent from alcohol and other psychoactive drugs, the treatment is deemed successful. Determining the outcome of APM treatment is much more complex.

It is not enough for patients to achieve abstinence from inappropriate medication. They must also experience an improvement in their pain condition and quality of life. In addition, they must have a solid relapse prevention and pain management plan in place that continues to be evaluated and modified frequently.

Benchmarks For Effective Treatment (Grinstead & Gorski, 1999). Patients should schedule follow up reviews with their treatment team to be completed at different intervals, using specific benchmarks that gauge successful treatment. The first follow-up occurs at the completion of the APM treatment process, followed by reviews at three months, six months, nine months, and one year.

These benchmarks include assessing improvement in quality of life. Improvements are determined by such factors as patients returning to work, or other significant increases in the quality of their life as well as the absence, or significant reduction, of psychoactive drug use. Family members and significant others should be asked for their input.

To be considered a total treatment success the following criteria must be met: After one year patients must be taking no inappropriate addictive chemicals, report an increase in their quality of life, and report a decrease both in their inactivity due to pain and in their pain levels.

However, it is important to realize that in some cases the most optimal outcome will be a reduction in the patients medication—or changing to a safer and more effective medication—not total elimination.

CONCLUSIONS

Utilizing the APM modality increases positive treatment outcomes for chemically dependent chronic pain patients. Employing detailed and accurate assessments followed by multidimensional treatment plans are the starting point. The next step is combining the effective approaches used in both pain clinics and chemical dependency treatment centers and then modifying them for use with this particular population. An eclectic approach that is flexible enough to include non-traditional treatment modalities such as chiropractic, meditation training, acupuncture, hydrotherapy, and massage-therapy is established, and followed with a relapse prevention program. The implementation of this APM methodology will prove that more patients benefit from this type of treatment than from either chemical dependency treatment or pain management care at a chronic pain clinic alone, enabling them to resume healthy and productive lives.

SUGGESTED ADDITIONAL READING AND RESOURCES

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