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Prescription Drug Addiction

by Rod Colvin

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Contents

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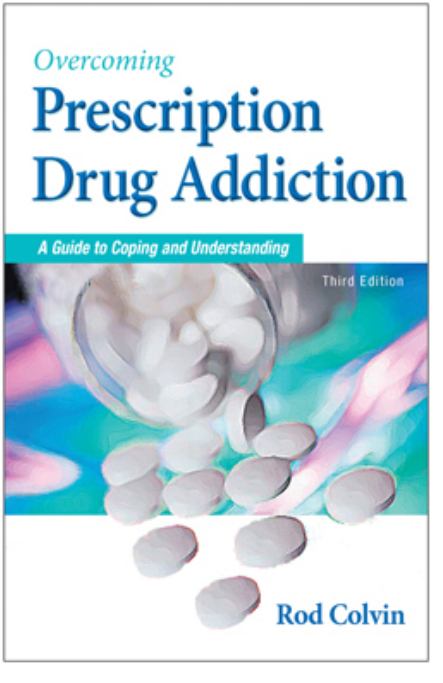

Understanding Addiction

Somewhere, at this very moment, a man's wife agonizes as she receives a call from the police—her husband has been arrested for forging prescriptions for tranquilizers. In another community, a mother weeps as her adult daughter, intoxicated on painkillers, disrupts yet another family gathering. In a small Midwest town, a family is grieving the death of their teenage son who died at a party from an overdose of prescription anxiety medication and alcohol. The case scenarios go on and on. Legions of Americans are abusing and becoming addicted to prescription drugs.

In fact, chances are you know someone who is abusing prescription drugs. Maybe it's your spouse, a relative, a friend, or a casual acquaintance. Maybe it's you.

Defining Addiction

Addiction is a pattern of compulsive drug use characterized by a continued craving for drugs and the need to use these drugs for psychological effects or mood alterations. Many abusers find that they need to use drugs to feel "normal." The user exhibits drug-seeking behavior and is often preoccupied with using and obtaining the drugs of choice. These substances may be obtained through legal or illegal channels.

The American Society of Addiction Medicine considers addiction "a disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological, or social harm." Addiction is a chronic disease that is progressive—it worsens over time. It can be diagnosed and treated, but without treatment, it is ultimately fatal.

How Addiction Affects the Brain

It was once thought that addiction was a result of being weak-willed—addicts could stop using drugs if they *wanted* to. But research has shown that this is not the case. In fact, after prolonged use of an addictive substance, the "circuits" in the brain virtually become "rewired."

When a medication enters the brain, it is absorbed through receptor sites. Addictive drugs are believed to act on the brain by reinforcing the action of the body's natural chemical, known as dopamine, that is involved in producing the sensation of pleasure. When the body is getting such chemicals from an outside source, the brain stops making some of its own and becomes dependent on the outside source. As the brain adapts to the drug's presence, the individual using the drug builds tolerance and must continually increase the dosage in order to achieve the initial pleasure sensations. However, most addicts in recovery report that they rarely achieved that initial sense of euphoria or feeling of well-being again.

Further, if the drug is stopped abruptly, it usually triggers a withdrawal syndrome. Symptoms of withdrawal may vary depending on the length of the addiction and the drug being used, but common symptoms from painkillers may include anxiety, irritability, chills alternating with hot flashes, salivation, nausea, abdominal cramps, or even death. Some individuals describe withdrawal as the worst possible flu you can imagine. As one goes into withdrawal, the body "begs" for more of the addictive drug in order to escape the misery. Understandably, giving up the drug is difficult.

This inability to stop using the drug is a characteristic of addiction. Although an addicted individual may intellectually understand the destructive consequences of addiction, he or she may not be able to stop the compulsive use of a drug; the changes in brain structure can affect emotions and motivation, both of which affect behavior.

Another common characteristic of addiction, *denial,* makes it even more difficult for the addicted individual to give up a drug. Denial refers to the addict's belief that he or she really does not have a drug problem. This self-protective mechanism is governed by the subconscious areas of the brain where the main addiction pathways exist. Denial keeps the addict from acknowledging both the drug problem and the underlying emotional issues that may be influencing the use of drugs. Usually, the longer the drug abuse has gone on, the stronger the denial.

Drug Misuse

There are levels of drug abuse. *Drug misuse* refers to drugs unintentionally being used improperly by people hoping to get a therapeutic benefit from the drugs. Misuse includes many scenarios, ranging from the patient who stops taking a medication on his or her own, to the patient who may be exchanging drugs with family members or friends.

Medication misuse causes thousands of deaths and hospitalizations each year, and the cost to the economy is in the billions of dollars.

Another potentially fatal misuse of drugs involves painkillers or sedatives taken in combination with alcohol. Even though a drinker may have developed a tolerance to the sedative effects of alcohol, he or she will not have developed a tolerance for the alcohol's depressing effects on the respiratory system. The combination of alcohol and tranquilizers or sedatives can create cardiorespiratory depression and lead to death.

Drug Abuse

Drug abuse refers to "the use, usually by self-administration, of any drug in a manner that deviates from the approved medical use or social patterns within a given culture. The term conveys the notion of social disapproval, and it is not necessarily descriptive of any particular pattern of drug use or its potential adverse consequences," according to *The Pharmacological Basis of Therapeutics* by Jerome Jaffe. Drug abuse may include using a medication "recreationally," using it for reasons other than those intended, or using the drug more frequently than indicated by the prescriber. Abuse may or may not involve addiction.

It is estimated that as much as 28 percent of all prescribed controlled substances are abused. That estimate translates to tens of millions of drug doses being diverted annually for the purpose of abuse. *Diversion* refers to the redirecting of drugs from legitimate use into illicit channels. The drugs may be obtained through any number of sources—by bogus prescriptions, from a friend, or purchased on the streets.

How Many Americans Are Abusing Prescription Drugs?

It's difficult to say with precision just how many Americans are abusing prescription drugs, although estimates are available. According to 2007 statistics, nearly 17 million Americans aged twelve or older reported having used prescription drugs—painkillers, sedatives, tranquilizers, or stimulants—for nonmedical purposes during the year. In fact, the number of people abusing prescription drugs is greater than the combined number of people using cocaine, hallucinogens, inhalants, and heroin. Overall, 56 percent more Americans abuse prescription drugs than these illegal drugs.

Teen Abuse on the Rise

Prescription drug abuse among teenagers has tripled since 1992. Today, nearly 19 percent of all teens report having taken a painkiller for nonmedical purposes. Prescription drug abuse among college students is estimated at 20 percent.

The National Center on Addiction and Substance Abuse at Columbia University reports that more than half the nation's twelve-to-seventeen-year-olds are at risk of substance abuse because of high stress, frequent boredom, too much spending money, or a combination thereof. Unfortunately, many teens believe that prescription drugs, such as painkillers, are safer than illegal street drugs, and many are not aware of the addiction risks associated with narcotics. Many teens report getting drugs from their family medicine chest or from friends.

Statistics on Teen Drug Abuse

- One in five teens (19 percent) have used prescription drugs to get high.
- One in four teens report having a friend who uses pills to get high.
- One in three teens report being offered pills for recreational use.
- Every day, 2,700 teens try a prescription drug for the first time to get high.

Source: Partnership for a Drug-Free America

Emergency Room Visits on the Rise

The number of prescription drug abusers seeking treatment in emergency rooms is also on the rise. In 2005, drug and alcohol abuse sent nearly 1.5 million people to hospital emergency rooms. To make the magnitude of this statistic more real, imagine every man, woman, and child in

the city of Philadelphia going to a hospital emergency room as the result of substance abuse.

Overdoses on the Rise

Fatal poisonings from drug overdoses are rising dramatically in the United States. Officials say most of these deaths are from prescription drugs rather than illegal drugs such as heroin. According to the Centers for Disease Control (CDC), more than 33,000 Americans died of drug overdoses in 2005, the most recent year for which statistics are available. This number makes drug overdose the second leading cause of accidental death. (Traffic accidents are the leading cause of accidental deaths.)

In 1990, the CDC reported 10,000 drug overdose deaths; in 1999, the number was 20,000. The 2005 death toll represents a 60 percent increase in drug-related deaths between 2000 and 2005. The government estimates that such abuse costs about a half trillion dollars a year, or about $1,650 per American.

Addiction Rate in the United States

It's generally believed that between 10 and 16 percent of Americans are chemically dependent at some point in life. These percentages refer to all addictive substances, including alcohol, prescription medications, and illegal substances, but do not include tobacco. Many individuals in recovery report that they often used both alcohol and prescription drugs, depending on their availability. A 1998 report by the University of Chicago states that multidrug consumption is the normal pattern among a broad range of substance abusers.

Symptoms of Addiction

Prescription drug abuse is often difficult for friends and family to recognize. Contrary to popular belief, one need not abuse drugs daily to have a problem with addiction; the pattern of abuse may be occasional or habitual. The abuse is usually an intensely private affair between the abuser and a

bottle of pills. And the pill taker is not subject to the social stigma associated with the shadowy world of street-drug dealing. Still, the following are symptoms of addiction:

- Showing relief from anxiety
- Changes in mood—from a sense of well-being to belligerence
- False feelings of self-confidence
- Increased sensitivity to sights and sounds, including hallucinations
- Slurred speech and poor motor control
- Decline in hygiene and appearance
- Altered activity levels—such as sleeping for twelve to fourteen hours or frenzied activity lasting for hours
- Lack of interest in activities previously enjoyed
- Unpleasant or painful symptoms when the substance is withdrawn
- Preoccupation with running out of pills

Who's at Risk for Addiction?

Who is at risk for addiction? Medical science has also determined that those with a family history of addictions have

Distinguishing Medical Use of Drugs from Nonmedical Substance Use

	Medical Use	Nonmedical Use
Intent	To treat diagnosed illness	To alter mood
Effect	Makes life of user better	Makes life of user worse
Pattern	Steady and sensible	Chaotic and high dose
Legality	Legal	Illegal (except alcohol or tobacco use by adults)
Control	Shared with physician	Self-controlled

From "Benzodiazepines, Addiction and Public Policy," by Robert L. DuPont, M.D., *New Jersey Medicine*, 90 (1993): 824-826. Reprinted by permission.

about a threefold greater risk of developing addictions. But, in addition to family history, there are other risk factors.

The risk for addiction is greatest among women, seniors, and, as mentioned earlier, teenagers. Women are two to three times more likely than men to be prescribed drugs such as sedatives; they are also about two times more likely to become addicted. This stems in large part from the fact that women are more likely to seek medical attention for emotional problems. Seniors take more drugs than the rest of the population and have a reduced capability of breaking them down and eliminating them; this increases their odds of becoming addicted. And the surge in teenage abuse of prescription drugs has led to dependency among many. Other groups at increased risk for addiction are medical professionals, alcoholics, and smokers.

Other factors that put one at risk for addiction include:

- Medical condition that requires pain medication
- Extreme stress from family tragedy or death
- Divorce
- Excessive alcohol consumption
- Fatigue or overwork
- Poverty
- Depression
- Dependency
- Poor self-image
- Obesity

Is everyone who takes addictive drugs at risk for addiction? The answer is no. "Twenty years ago, it was widely believed that virtually anyone who took psychoactive drugs was a likely candidate for dependency, but that thinking has changed," states Bonnie Wilford, Executive Director of the Alliance for Prescription Drug Abuse Prevention. "Our change of thought has come about as a result of our increased knowledge about addiction. For example, perhaps seven out of ten people could take tranquilizers and not progress to

addiction. But those who do become addicted likely have a preexisting addictive disorder, such as predisposition to alcoholism. The difficulty is, we don't always know which patients this will be."

The "Unwitting" Addict

Many individuals who become dependent on prescription drugs are "unwitting" addicts. These are individuals who have no prior history of drug abuse or addiction. They started using a prescribed drug for a legitimate problem, physical or emotional. For example, it may have been a painkiller for a back injury or a sedative for anxiety. Then, at some point, these individuals started increasing the dosages on their own because the drug made them feel better—giving them relief from physical or emotional distress. The nature of the drug required that they continue escalating the dosages to get the desired effect. Gradually, the abuse became full-blown addiction.

Which Drugs Are Being Abused?

According to the Drug Abuse Warning Network, prescription drugs are among the most abused substances in the United States; these drugs are abused more than heroin and cocaine combined. Only marijuana use is more common than prescription drug abuse.

At the top of the list of prescription drugs being abused are benzodiazepines and painkillers. The Drug Abuse Warning Network keeps a ranking of such drugs, based on information gathered during hospital emergency room visits across the nation. The patient must indicate that a drug was being used for purposes of recreation or dependence in order for the episode to be considered drug abuse.

Commonly Abused Prescription Drugs

Opioids

Opioids, more commonly known as painkillers, belong to a class of drugs also known as *opiates* and are typically prescribed to relieve acute or chronic pain, such as that from cancer or surgery. These drugs are also referred to as *narcotic analgesics* or pain relievers. For acute pain, opioids are normally used only for short periods—fewer than thirty days. Opioids may be taken orally or by injection.

Although they are medically indicated for the control of pain, opioids are drugs with high abuse potential. In addition to blocking pain messages being sent to the brain, opioids produce feelings of euphoria or pleasure. It is this sensation that makes the drug highly sought after by those wishing to free themselves from painful emotions. Chronic use of opioids results in both tolerance and dependence.

Common opioid products include:

- Darvocet-N
- Demerol
- Lorcet
- Methadone
- OxyContin
- Percodan
- Roxiprin
- Tylenol with Codeine
- Darvon
- Dilaudid
- Lortab
- Morphine
- Percocet
- Roxicet
- Tussionex
- Vicodin

According to the National Institute on Drug Abuse, the number of opioid prescriptions in the United States escalated from nearly 40 million in 1991 to 180 million in 2007. That's an increase of 350 percent at a time when the population increased by 19 percent.

Opioid Withdrawal

Stopping the use of opioids suddenly will bring on symptoms of withdrawal. Initial withdrawal symptoms usually

Most Abused Prescription Drugs in the United States

1. Alprazolam *(Xanax)*
2. Hydrocodone *(Lorcet, Lortab, Vicodin)*
3. Unspecified benzodiazepines
4. Oxycodone *(OxyContin, Percocet, Percodan, Tylox)*
5. Methadone
6. Clonazepam *(Klonopin)*
7. Propoxyphene *(Darvocet-N, Darvon)*
8. Amphetamine *(Dexedrine)*
9. Lorazepam *(Ativan)*
10. Carisoprodol *(Soma)*
11. Diazepam *(Valium)*
12. Methamphetamine *(Desoxyn, speed)*
13. Trazodone *(Desyrel)*

Source: From Drug Abuse Warning Network Emergency Room Data. Based on drugs mentioned during emergency room visits in 2005.

begin within hours of the last dose and may include: cravings, running nose, excessive sweating, insomnia, and violent yawning. Those who have been addicted to opioids for a long time may progress to severe withdrawal symptoms, including: chills, fever, muscle spasms, and abdominal pain. Opioid withdrawal is rarely fatal.

Cessation of opioids is best accomplished under medical supervision, where withdrawal can be managed. A medically assisted withdrawal is safer and also increases the chance that an individual will "come off" a drug.

Stimulants

Stimulants are drugs that stimulate the central nervous system, increasing mental alertness, decreasing fatigue, and producing a sense of well-being. These drugs are often

prescribed for attention deficit (hyperactivity or ADHD) disorder and narcolepsy, a condition characterized by excessive daytime sleepiness, even after adequate nighttime sleep. Common stimulation drugs include:

- Adderall
- Cylert
- Ritalin
- Concerta
- Dexedrine

Interestingly, while the drugs listed above stimulate the central nervous system in adults, they have a calming effect on children. Consequently, these stimulants are often prescribed for children diagnosed with ADHD. The drugs produce a calming effect in these children by stimulating nerves that slow down other overactive nerves.

In adults, other stimulants such as Adipex-P, Bontril, Didrex, Ionamin, Meridia, Prelu-2, Pro-Fast, and Tenuate may be used to suppress appetite.

Stimulants such as Dexedrine and Ritalin increase the amount of the natural brain chemicals *norepinephrine* and *dopamine*. The increased levels of these chemicals create both an increased heart rate and increased blood pressure and a sense of pleasure, resulting in an overall sense of heightened energy and sense of well-being. Once accustomed to an outside source of these chemicals, the body craves more of them.

Anyone taking high doses of stimulants runs the risk of irregular heartbeat and high blood pressure, which can result in heart failure. High doses may also result in feelings of hostility and paranoia.

Stimulant Withdrawal

Symptoms of withdrawal from stimulants include: depression, fatigue, loss of interest or pleasure in daily activities, insomnia, loss of appetite, suicidal thoughts and behavior, and paranoid delusions.

Sedatives

Sedatives are drugs that depress the central nervous system and are frequently used to treat anxiety, panic disorder, or insomnia; some are also used for seizure disorders. As these drugs interact with chemicals in the brain, they cause a reduction in brain activity and bring about the sedative effect.

Benzodiazepines, often referred to as "benzos," are among the most commonly prescribed sedatives. Those often prescribed for daytime use are:

- Ativan
- Librium
- Serax
- Tranxene
- Valium
- Xanax

Benzodiazepines frequently used for nighttime insomnia are:

- Doral
- Halcion
- ProSom
- Restoril

Benzodiazepines used for seizure disorders are:

- Ativan
- Klonopin
- Tranxene
- Valium

Benzodiazepine Abuse

Benzodiazepines are among the most abused prescription drugs in the nation. They were first introduced into American medicine in 1960 to control anxiety. Today, it's estimated that between 10 and 12 percent of the population use benzodiazepines within the course of a year. According to the Drug Abuse Warning Network, most deaths from benzodiazepines are caused by combined use with alcohol.

Short-Term vs. Long-Term Use

Debate continues in the medical community over the safe, long-term use of benzodiazepines, since the buildup of tolerance is often rapid, and severe withdrawal can occur if

these drugs are stopped abruptly. Short-term use is considered a few weeks or less; long-term use refers to several months or more. The debate prompted the American Psychiatric Association to issue a statement claiming, "Physiological dependence on benzodiazepines...can develop with therapeutic doses. Duration of treatment determines the onset of dependence...clinically significant dependence usually does not appear before four months of such daily dosing. Dependence may develop sooner when higher, anti-panic doses are taken daily."

Questions Doctors Should Consider before Prescribing Long-Term Use of Benzodiazepines

1. **Diagnosis and response to treatment.** Does the patient have a clear-cut diagnosis, and does the patient respond favorably to the use of the benzodiazepine?
2. **Use of psychotropic substances.** Is the patient's use of alcohol and other substances legal and sensible? Does the patient avoid all use of illegal drugs? Is the benzodiazepine dose reasonable? Is the use of other prescribed drugs medically reasonable?
3. **Toxic behavior.** Is the patient free of slurred speech, accidents, or other problems that may be associated with excessive or inappropriate use of any prescribed or nonprescribed psychoactive substance?
4. **Family monitor.** Does a family member confirm that the patient's use of the benzodiazepine is both sensible and helpful and that the patient does not abuse alcohol or use illegal substances?

A "no" answer to any of these questions suggests the need to discontinue benzodiazepines. A "yes" to all four questions supports continuation of benzodiazepine prescriptions if that is the shared conclusion of the patient and the physician. The standard to be met: Is this treatment clearly in the patient's best interest?

From "Benzodiazepines, Addiction and Public Policy," by Robert L. DuPont, M.D., *New Jersey Medicine* 90 (1993): 824-826. Reprinted by permission.

Benzodiazepine Withdrawal

Symptoms of withdrawal from benzodiazepines and other sedatives include: insomnia, anxiety, depression, euphoria, incoherent thoughts, hostility, grandiosity, disorientation, tactical/auditory/visual hallucinations, and suicidal thoughts. Symptoms can progress to include: abdominal cramps, muscle cramps, nausea or vomiting, trembling, sweats, and seizures.

Anyone who has used benzodiazepines over an extended period of time—several weeks or more—should never stop taking the drug abruptly. After long-term use, medically unsupervised withdrawal can be severe, leading to delirium, fever, seizures, coma, and even death. Individuals wishing to stop the drug should ask their physicians about being medically supervised so that withdrawal can be managed as use of the drug is tapered.

Another symptom of withdrawal is "symptom rebound," an intensified return of the original symptoms (such as insomnia or anxiety) for which the drug was first prescribed. This rebound is often misinterpreted by patients as a recurrence of anxiety.

History of Addiction and Benzodiazepines

Some of the controversy surrounding the use of benzodiazepines has resulted from the dependency problems occurring among patients who have had previous problems with addiction. "Patients who have a history of chemical dependence, including the use of alcohol or drugs, are poor candidates for use of benzodiazepines in the treatment of anxiety," states Robert L. DuPont, M.D., former director of the National Institute on Drug Abuse. "Anyone who has used illicit drugs repeatedly over a period of months or years, and anyone who drinks more than a few drinks of alcohol a week, should use benzodiazepines with extreme caution, if at all."

Distinction between Addiction and Physiological Dependence

Addiction

- Loss of control of drug use
- Continued use despite problems caused by use
- Denial
- Relapse
- A complex, biobehavioral, lifelong, malignant problem
- Limited to chemically dependent people
- Not a complication of medical treatment unless a prior history of chemical dependence exists
- Best treated by specific chemical dependence treatment

Physiological Dependence

- A cellular adaptation to the presence of a substance
- Withdrawal symptoms on abrupt discontinuation
- Not associated with relapse
- A benign, temporary problem
- Common to many substances used in medicine including steroids, antidepressants, and antiepilepsy and antihypertensive medicines
- Best treated by gradual dose reduction

Physiological Dependence and Addiction: The Difference

Not all drug dependence is addiction. *Physiological dependence,* which is often confused with addiction, is a result of the body's adaptation to a drug used over a period of time to treat a medical disorder. For example, a patient taking pain medication for several weeks would likely develop some degree of tolerance to the drug; he or she would become physically dependent, and would have withdrawal symptoms if the drug were stopped abruptly. This type of dependence, however, is *not* addiction. A patient with a physiological dependence can quit the drug, usually by being tapered off it gradually, with medical supervision and without admission into a drug treatment program.

Prescription Drug Abuse Checklist

Ask yourself the following questions about opioids, sedatives, and stimulants:

- Have you been taking sleeping pills every day for more than three months?
- Do you sometimes take pills in order to make life more bearable?
- Have you tried to stop taking pills and felt vulnerable or frightened?
- Have you tried to stop taking pills and felt your body start to tremble or shake?
- Do you continue to take pills even though the medical reason for taking them is no longer present?
- Do you think pills are more important than family and friends?
- Are you mixing pills with wine, liquor, or beer?
- Are you taking one kind of pill to combat the effects of another pill?
- Do you take pills to get high and have fun?
- Do you take pills when you're upset or to combat loneliness?

- Do you feel happy if your doctor writes a prescription for drugs that change your mood?
- Do you visit several doctors to get the same prescription?
- Are you taking more pills to achieve the same effect you used to experience with smaller doses?
- Do you find it difficult to fulfill work obligations when you're taking pills?
- Do you ever promise yourself that you will stop taking pills, and then break the promise?
- If you answer yes or *sometimes* to three or more of these questions, you may be developing a problem with drug dependence. Talk with a chemical dependency counselor or doctor who specializes in treating drug problems. For referral to a local resource, call 1-800-NCA-CALL (1-800-622-2255).

Insights on Recovery from Addiction Medicine Physicians

All too often, individuals in recovery say they didn't seek treatment early enough or they went to health professionals who didn't understand or diagnose their addiction. Consequently, proper treatment was delayed. Because addiction is an illness that requires first diagnosis and then treatment, it is important that we avail ourselves of those health professionals who understand chemical dependency and how it is treated.

In this chapter, you'll hear from experts on addiction, including addictionologists from the American Society of Addiction Medicine (ASAM), who have treated thousands of individuals for chemical dependency. ASAM is an international association of 3,000 physicians dedicated to improving the treatment of alcoholism and other addictions.

Addiction Is an Illness

Sidney Schnoll, M.D.
Addictionologist

Our culture today too often looks upon addicts as we did epileptics 400 years ago—we burned them at the stake

because we thought they were possessed. Today, we know that people with drug addiction have a disease that requires specific treatment. People who are addicted are suffering from an illness, just as one suffers from diabetes or any other illness. Yet, many addicts are viewed as having something morally wrong with them—as if it's something they bring upon themselves.

I became interested in substance abuse and addiction more than thirty years ago when I was a resident at Philadelphia General Hospital. I saw a lot of young people coming in with problems from LSD use. No one quite knew how to take care of them.

There is no one treatment for most diseases. And so, there is no one specific treatment for addiction. We're talking about roads to recovery, rather than one road to recovery. There is not one shoe that fits all. I think one of the biggest mistakes made in the field of addiction is that people make the assumption that there's one way to recover and if you don't do it that way, there's something wrong with you. For example, not every diabetic needs insulin. And those who get it take different doses. And diabetics have different courses of progression in their disease. The same is true for addiction. It is a chronic disease just like diabetes. We can treat it, but we cannot cure it. We can control some of the symptoms. We can make some people's lives very comfortable; other people do not do as well.

Anyone who needs help with addiction should seek out the assistance of someone trained in the diagnosis and assessment of the problems of addiction. Addiction is not something that most physicians are adequately prepared to treat.

Building on Hope

LeClair Bissell, M.D.

Addictionologist

I'm a recovering alcoholic, so I became interested in recovery issues during my own recovery. Some years later, I went to medical school and went on to practice addiction medicine full time. My writing and research has dealt almost exclusively with substance abuse and chemical dependency.

If someone who's battling addiction feels hopeless, I would offer them the experience of other people who have recovered, along with the understanding of what the patient is feeling emotionally at the moment. Empathy without sentimentality. Also, if they're feeling really hopeless, I would make a note to myself to see if there have been suicide attempts, and if so, how many. I'd also want to evaluate for depression. If one has come to treatment on his own, he must have a pinch of hope that things might get better; otherwise, he wouldn't be there.

When it comes to treating prescription drug addiction, there are some attitudinal differences when comparing it to alcoholism. For example, a good many individuals might think it's naughty to drink, but that it's okay to have certain sedative-hypnotic pills if the doctor has prescribed them. The truth is, these drugs are in the same "family" as alcohol. But pills aren't seen as being as bad as alcohol.

And all too often, these addicts are hard to spot for doctors who haven't had the training. If the patient comes in with a clean white shirt and clean fingernails—not the stereotype of the drug addict—many doctors will not realize the patient is an addict. The diagnosis of addiction is often made by caste and class and is made late rather than early.

If you are an addict or alcoholic in recovery, it's very important to tell your doctor so that you aren't given addictive drugs or cough syrups with alcohol. Doctors need to take a patient's history before prescribing drugs. We need to use

these drugs of addiction as little and for as short a time as possible.

Over the years, I saw many patients who were doing quite well in recovery from alcoholism, but went to a physician and were given sedatives or tranquilizers. Then their mood swings began, and ultimately, they began to drink again. When someone in a case like this takes the sedatives and then a couple of drinks, they become very relaxed. But in a matter of a few hours, they're going to be more tense than when they started. That's when they're in rebound, the return of original symptoms which is part of withdrawal. They're having these intense emotional ups and downs. If you're an alcoholic, you already have a body that knows perfectly well what you can do when those up periods feel too uncomfortable—you use more chemicals.

I'm not saying anything whatsoever about the minor use of tranquilizers by people who are not addicts. There's quite a body of information that says these drugs are pretty safe for occasional use. But for those who have already had problems with alcohol or other drugs, it's a bad idea to start taking other mood-changing drugs.

I always give this word of warning about drugs of addiction: Whenever you take a drug and it really changes the way you feel, makes you feel really good—be careful. It may be something you should not have.

Let me stress that there are untold thousands who can use drugs wisely. But as a doctor in addiction medicine, I've seen only the casualties over the years. I never saw the patients who took only a few pills and used them wisely. I saw people who got into bad trouble and then came to me for help. I would say to those recovering from prescription drug addiction: Be patient. It may be a while before you feel a lot better. I saw this especially with benzodiazepines. For example, someone could be clean for two months and still not feel well. It's easy to get discouraged and go back to the pills. They need to hang on—it won't always be as bad.

Finally, I would like to share some thoughts with families. As part of my work, I also saw many family members who suffered deeply because of a loved one's addiction. When family and friends are trying to cope with an addict, it's important for them to understand several things. One, the relative or friend has to realize that they did not cause the problem and they cannot, by themselves, resolve it. Even if the addict is blaming them, they must realize they're not responsible.

Equally important, the relative has got to stop making it easy for the addict to stay sick. The parent who constantly pays the fine or bails his kid out of jail is enabling. The addict does not have to face the consequences of his or her own behavior.

Another important thing for the family to know is what a doctor recommends for the patient, if treatment is underway. For example, the patient might visit a doctor and then go home and tell the family the doctor said it was okay to take a drink or a few drugs once in a while. It helps if the family knows that the physician has recommended *total* abstinence from alcohol and all other mood-changing drugs of addiction.

Be Cautious with Benzodiazepines

Ronald Gershman, M.D.
Addictionologist

I was a psychiatrist in private practice for twenty years. Most of that time, I worked in the treatment of chemical dependency. I treated about 10,000 patients for alcohol and drug problems and detoxed approximately 1,500 patients for benzodiazepines, a strong focus of mine.

When it comes to treating patients, I see two patterns. First, there is essentially the drug addict who supports an addiction through the use of prescription pills. These patients see themselves as different from other addicts; they often think their prescribed medication is justified even though they may be manipulating and deceptive in acquiring excessive

amounts of drugs. Second, I see the individuals we call the "unwitting" or "iatrogenic" addicts. These patients were put on medication (especially benzodiazepines) for legitimate reasons, but for an extended period of time, and they became addicted.

How do such addictions occur? Benzodiazepines aside for a moment, let's look at opiates, which are commonly used to treat pain. When people take an opiate medication, the drug relieves physical pain and it also relieves emotional pain. The problem of abuse comes in using the drug to relieve emotional pain.

For most patients, if they're using the drug strictly to relieve physical pain, when the physical pain is gone, they can give up the drug. But if they're depressed or anxious or life is miserable for them, then the drug use can become a problem after the physical pain is eliminated. The emotional pain is still there and they still want to treat that pain. From what I've seen, this is a pretty clear pattern, but it's not easy to tell which patients might end up seeking the drug for emotional pain once they've healed physically.

The treatment for addiction differs dramatically, depending on the nature of the drug you're treating. For example, treatment for a benzodiazepine addiction is very different from treatment for an opiate such as Vicodin or codeine.

Managing the withdrawal and keeping the patient from relapsing is the real crux of the problem. The detox for opiates is about seven to ten days and can usually be done on an outpatient basis. I used about eight different medications to help patients get through detox. Among the medications we used was an opiate blocker, which prevented an opiate from "working" if the patient relapsed. We also used antidepressants because the depressions are quite severe and are a major cause of relapse. Then, with therapy, we helped the patient learn to live and manage a sober life, which is really the heart and soul of the work that needs to be done. Detox is usually quite successful if the patient is highly motivated.

But detox for benzodiazepines is more difficult. It takes longer, ranging perhaps from six to eighteen months. In this recovery, the ongoing, relentless withdrawals can be incapacitating. The "fallout" from addiction to these drugs can lead to the breakup of marriages, the loss of businesses, and hospitalizations. Unfortunately, suicide is probably the single most serious side effect.

All too often, doctors do not recognize this withdrawal pattern. The patient has been on the drugs for a year or so and then the doctor says, "I don't think you need these anymore," and takes them off. In a few days, when the patient breaks down, the doctor and patient assume the "old psychiatric problem" is returning. The patient is hospitalized and put on drugs. This cycle can prevent getting to the root of the dependency problem.

If benzodiazepines are used inappropriately and the patient becomes addicted, the patient builds tolerance and the drugs stop working. In fact, over a long period of time, their usage can worsen the condition they were being used to treat. What happens is, the level of the drug in the blood drops between doses, which quickly brings on withdrawal symptoms. So the drug is losing its effectiveness, while the withdrawal is making symptoms three or four times worse than they were before.

I believe benzodiazepines are appropriate for short-term management of acute anxiety or panic attacks. Short-term use generally means two to six weeks, the absolute maximum I would recommend.

Using Benzodiazepines Responsibly

David Mee-Lee, M.D.
Addictionologist

There is disagreement in the medical community about the use of benzodiazepines. Although some say benzodiazepines are overused, others would say the opposite, that

they're being underutilized out of doctors' concerns that patients will become addicted.

Opinions vary, even by country. Britain has been very strict in limiting use of benzodiazepines to shorter-term use. In the United States, the fear of abuse has been overblown and patients are being robbed of adequate use because of fear of addiction.

My view is that these drugs are like alcohol, in that not everyone is going to use them inappropriately. I think long-term use can be acceptable as long as the risks and benefits are weighed cautiously and careful assessment of the patient is done to make sure those at high risk for addiction are screened out.

Even if a patient is not at high risk for addiction, the physician should always periodically reassess the use of any medication to see if the patient still needs it. I don't believe drugs should be prescribed blindly just because the patient is not becoming addicted. There are other ways to cope.

Of course, anyone taking even therapeutic doses of a benzodiazepine for a period of time will become tolerant of the drug and will have to be gradually withdrawn from it. To quit abruptly would cause withdrawal. But not everyone would have to be detoxed on an inpatient basis.

The people who often get in trouble are those who have escalated their use of the drug; they take high dosages and are often in a poor recovery environment. They may also lack emotional support and have poor impulse control in terms of relapse. Most people will do better if they have motivation to come off the drug and have resources, both personal and environmental, to help them deal with impulsive use.

We need to understand a couple of basics about addiction. One, addiction affects not only the person using, but those around them—family and friends. There are very few families who aren't affected by addiction in some way. Also, the one who has the problem needs to acknowledge that there is a problem. Family members and others can be helpful by confronting and not rescuing the person.

The patients who obtain pharmaceuticals through legal means, but yet escalate dosages and abuse the drugs, often have trouble admitting their problem. They tend to say they were just doing what their doctors told them. They don't see themselves as addicts. We try to help these patients see that their drug use has been negatively affecting their lives. Some of these patients come to treatment once their doctor has judged they've become addicted and has stopped prescribing. The patients are sometimes left not knowing what to do if they're not guided into treatment.

What goes into successful recovery? Anyone *can* succeed. But the degree of difficulty in recovering depends on how much damage has already been done. Has the patient lost jobs, family, and physical health? The more one has lost, the harder recovery might be.

Recovery from addiction is similar to recovering from other chronic illnesses. You have to keep monitoring it to make sure you're taking care of yourself. It means continuing in some kind of recovery program. That doesn't mean going to support groups daily for the rest of your life, but rather continuing to be vigilant about relapse and using support groups or other methods to stay aware.

Some people can recover with little help—not everyone goes through treatment. They come to the awareness that they have a problem and decide to do something about it. However, many others need help.

And in the scenario in which the addict won't go into recovery, his or her family can still recover. They can learn to stop playing into the addict's agenda and learn to stop passing the problem on down through generation after generation.

In short, people with chemical dependencies must first admit that they have an illness; second, realize they're at risk for relapse; and third, recognize that they need ways to cope with stress or problems if they're heading toward relapse. Addiction is a chronic illness, not a moral problem. It needs treatment, not judgment.

Stages of Chemical Dependence

Stage	Description
Abstinence	Person has not begun to use the drug, but attitudes are developing
Nonproblem use	No negative consequences of use
High-risk use	Use is frequent, heavy, or usage patterns are dangerous
Problem use (or abuse)	First negative consequences arise from usage patterns
Chemical dependence: Early stage	Reversible, less-serious negative consequences of threats do not motivate corrective adjustment of usage patterns
Chemical dependence: Middle stage	Irreversible negative consequences of use do not motivate significant corrective adjustment of usage patterns
Chemical dependence: Late stage	Multiple, serious, irreversible negative consequences have failed to motivate corrective adjustment of usage patterns

From "Finding Substance Abusers" by M.P. et al., 1984. *Family Medicine Curriculum Guide to Substance Abuse* (Society for Teachers of Family Medicine, Kansas City, Missouri). Reprinted by permission.

Addiction and Denial

Patrick Dalton
Certified Addiction Counselor

The individuals we see are outpatients. Many are addicted to prescription drugs. We insist that they divulge all information about the drugs they are taking in order for us to treat them effectively. Often, they're getting drugs from doctors who aren't aware of addiction issues. The doctor

might be trying to eliminate a patient's pain but not understand potential addiction problems. If the patient is prone to addiction, this can be like pouring gasoline on a fire.

Those dependent on prescription drugs have a mind-set different from that of alcoholics. Most of the people I've treated are very resistant to letting go of their drugs. They can partially justify it because they've gotten their drugs legitimately, from a doctor. They don't have the stigma of being a user of street drugs. This causes a high degree of relapse. In addition to this denial, those who are prescription-drug dependent have a real fear of not being able to cope without their drugs. They are very "med-seeking," always wanting a pill to fix them.

Some people don't realize they are prone to addiction, and they get hooked on a legal drug. They may not realize it until they start having negative consequences in their lives. When you use a chemical of any kind, once it has brought negative consequences to your life, you're crossing the line into addiction. Anyone who is aware of his or her addictive tendencies should always tell a treating physician.

Realizing Risk for Addiction

Sheila Blume, M.D.
Addictionologist

Not everyone who takes painkillers or sedatives gets addicted, but anyone who does take them should be warned of their addictive potential. In my experience, those who become addicted to these drugs fall into several categories.

The most common is the person who is an alcoholic but doesn't know it—the alcoholism hasn't been diagnosed, and the person is being seen for associated symptoms such as insomnia, tension, and difficulty concentrating. Then, an addictive drug is prescribed and the patient becomes addicted.

Equally unfortunate is the patient who has recovered from alcoholism but does not understand the potential of

other drugs and becomes addicted to them. These people may have recovered from earlier addictions on their own, without treatment or self-help groups. Many, many people do this. However, if they haven't been in a treatment program, they may not have been educated about other mood-altering drugs. Having this knowledge could have saved many self-recovering people from additional trouble.

I recall the case of one man, a recovering alcoholic, who had dislocated his shoulder. Because he had stopped using alcohol on his own, he really didn't see himself as an alcoholic. So, when he was given Tylenol with Codeine for pain, he got hooked on it and, in the end, it almost killed him.

All recovering addicts need to tell any doctor, including dentists, that they should not be given habit-forming drugs. If a doctor tells a recovering patient that the drugs won't cause dependency problems, but the patient still isn't sure, he or she should check with the pharmacist about any such dangers with the drug.

Another category of people who are susceptible to dependence are those in a lot of emotional distress or agitation. Once prescribed a sedative or tranquilizer, they can become dependent. For people who have not been drug dependent before, the first symptom of dependence is that the drug becomes very precious to them. They always make sure they have it with them at all times. They have the prescription refilled as soon as possible so they won't run out. The drug helps them, and they think it is the most wonderful thing in the world.

Then, when they hit a point where something bothers them emotionally, they take more of the drug and that feels good. They begin to increase the dose. At this point, they may get wary and decide not to tell their doctor about how they're using the drug. They fear their doctor won't approve and will stop prescribing. They begin to justify their use of the drug through denial or rationalization. They might start to manipulate the doctor, saying they lost a prescription or they're going on a trip and need extra pills. This works for only a short time, so then they'll have to switch to another doctor.

They may have five or six doctors they can reliably go to. They know exactly what drug they want when they schedule an appointment.

There is a point when abuse becomes addiction. Abuse refers to dangerous use, like taking a drug and driving when you should not be driving under the influence of the drug. Often, people can stop at abuse, but if they don't, they move on to dependence.

My message of hope is that prescription drug addiction is a treatable disease. Sometimes it's harder to do an intervention with prescription drugs than with alcohol or illegal drugs. Patients often believe they really don't need treatment. But treatment can help them return to a productive life. Recovery is very possible.

Addicts Are Not Having Fun

Howard Heit, M.D.

Addictionologist/Pain Specialist

When a person who needs treatment is reluctant to get help, I ask, "Are you having a good time?" The patient is usually taken aback by that because even though the public perceives that addicts are having a good time, the addict knows deep down that he or she is *not* having a good time. I remind them that they're not.

Why aren't they? First, they wake up each day worrying about their supply of pills, whether they're going to be able to "work" doctors for more drugs, or get drugs illicitly, which is very expensive. Second, they have a poor quality of life, given their drug-seeking behavior. So, if they're not having a good time, and their habit is expensive, degrading, and scary, I ask, "Why not try a program of recovery?" Most people will eventually agree.

I explain the kinds of changes that they have to make to stay in recovery. And, very early when they're having some difficulties making changes, I give them this homework assignment.

I ask them, "How long does it take you to drive home?"

"Half an hour," they may say.

"I want you to take an hour, take a long way home. And on your way home, I want you to count the number of dinosaurs that you see."

This causes them to stop and ponder my suggestion. "I'm not going to see any dinosaurs."

"Exactly," I respond. "The dinosaurs didn't adapt. They didn't survive. And now you have to make these adaptations or changes in your life if you want to stay on Earth. I will help you, but it takes work."

If they choose to work with me, I first take a very thorough medical history. The overwhelming majority of times, these are good people, solid people, intelligent. But, in their history, I might find such things as a sleep disorder, depression, or a psychiatric problem that has gone undiagnosed and untreated. These underlying causes are partly to blame for them using the drugs excessively and becoming addicted. I validate what has happened to them and again explain why their body has become used to or physically dependent on these medicines.

Consider the benzodiazepine Xanax, for example. I explain to a patient that I can safely wean him or her off Xanax by switching to a long-acting benzodiazepine. I point out that a short-acting benzodiazepine like Xanax has what we call an "off-and-on switch." That is, the level of Xanax in the blood fluctuates off and on, up and down, giving one the positive reinforcement, the craving, and the alteration of the biological and physiological system. These cravings kick in like clockwork with short-acting benzos, and the majority of the drugs of abuse are short acting.

I explain that I'm going to switch them to another drug in the same class that will go to the same receptor site on the brain, but it's a long-acting medication. Therefore, instead of falling off and on the receptor site, it will stay there for a twenty-four-hour period. Then what I do is slowly reduce the dose so that the brain gets used to slow reduction of the drug,

and we wean them off the medication. We never want to stop the benzo abruptly, since doing so can cause seizures.

I may further explain that I have also noted in their medical history a sleep disorder or other emotional problem. "It sounds like you have anxiety or are depressed. While we're working on this, let me place you on another medication—one that is nonaddictive—to help you with the sleep problem."

Here, I also stress the importance of changing behaviors. In the past, this patient conditioned himself or herself to reach for a pill when life becomes stressful. I introduce them to what I call a "Thoughts, Feelings, Actions, and Alternatives Diary." I ask them to record what happens when they feel the need to take a pill. They may write, "I want to take a Xanax. Why do I want to take a Xanax? I'm sad. My action is to take a Xanax. Wait a minute. What is my alternative? Maybe I will go and speak to my significant other and resolve this difficulty that we're having."

As another part of the treatment, I may also bring in a trained therapist to work on identifying and handling the "trigger points"—those stressors that make them want to use the drug. And so the recovery process is underway.

In short, the process works like this: You have the powerful primitive part of the brain that likes the feelings drugs bring; I call this part the "dark angel." And you have the "white angel," the intellectual part of the brain that handles thoughts, feelings, and actions. The task is to bring in the white angel to handle the dysfunctional trigger points that lead to destructive behaviors.

Warning Signs of Addiction

David Gastfriend, M.D.
Addictionologist

I would say about 15 percent of our practice involves prescription drug dependence. We see a range of patients. At one end of the range are patients who have been prescribed a

drug from the Valium family, like Xanax, for treatment of panic disorder. Initially they got relief from the drug, but then needed increased doses to achieve their state of comfort. Then they have difficulty coming off the medication, even though they want to discontinue it. This is a case of physiological dependence, not addiction, and it's very common with these medications even when they are used correctly and safely. Treatment is a matter of tapering the doses, educating the patient about what to expect, and teaching the patient to use behavioral techniques to cope with modest withdrawal symptoms. This is the most common problem we see.

At the other end of the range are those who are fully dependent on either alcohol, cocaine, or narcotics and are compulsively seeking to get high. They will use prescription drugs in combination with illegal drugs. Or, when they can't get heroin, they'll substitute with prescription opiates or benzodiazepines. They are truly addicted, manipulative, and compelled by their disease to beat the system. Often they feign illness to multiple doctors. These patients make up a smaller element of the overall problem, but it's a very costly problem in terms of death, emergency room visits, thefts, auto accidents, firearm accidents, and drug trading.

The mid-range of patients that I see are those who have been prescribed medications and who have psychological problems, although these problems initially may not have been apparent. Such problems include dependency on others, impulsiveness under stress, and paranoia. For these patients, certain drugs can create physiological and psychological dependence. This begins the cycle of addiction—compulsive use—resulting in an urge to use the substance at high personal costs.

We know there are individuals who are highly vulnerable to becoming alcoholic for genetic reasons, but we don't have reliable research on genetic vulnerability to addiction to anxiety medications and prescription narcotics. However, there are studies that infer that the same genetic

vulnerability exists. Many drugs have the same physiological effects as alcohol.

Patients in this category are often referred to us addiction specialists once their doctors realize they're being manipulated into prescribing excessive doses. The doctor may not want to cut off the patient completely from the drug and will call for a consultation with an addiction specialist.

There are warning signs that indicate prescription drug use is becoming problematic. Addiction problems could be arising when:

- You start to feel that the drug, at the same dose, isn't working as well as it used to.
- You feel the drug wearing off before it's time to take the next dose.
- You experience more than symptom relief as the drug takes effect; there is some degree of excitement or high. This indicates the dose may be excessive or that the medication may work too rapidly for safe, long-term use.
- You feel subdued or lethargic within a few hours of taking the medication. This may be an another indication that the dose is excessive.
- You're irritable and have problems sleeping. Here, the medication may be too short acting and may produce mild withdrawal over the course of the sleep cycle.
- You feel that you can perform certain tasks or engage in certain activities (like driving through traffic or socializing at a party) only with the benefit of the medication. This feeling increases with time.

If you note any of these warning signs, you should speak to your physician. Consider a consultation with an addiction specialist. Also, review your past history and your family history for substance use. Did your parents, grandparents, or siblings have problems with medications or substances like alcohol?

If a patient has run into problems with a drug, we expect them to take some responsibility for their behavior and ask for help. Many are afraid to ask questions for fear they'll be cut off from the drug and they'll suffer. But in order to reasonably and ethically prescribe some of these medications, the physician counts on the patient to be a partner in fostering good health.

Support Groups Help Avoid Isolation

Jeff Baldwin, Pharm.D.
Associate Professor of Pharmacy

It's important to recognize that there's not a specific level of drug or alcohol use that determines when you're addicted. For example, I've seen a woman who was alcoholic on one beer a day, and I've seen a man who was alcoholic on a case of beer a day. The better definition of addiction is "continuing to use a substance once it brings negative consequences to your life."

Once we do have an addiction, I believe one of the most important things for recovering is faithfully going to meetings, twelve-step or support groups. And recovering people who first go to twelve-step groups also should understand that they may need to be on some medications during their recovery. Although they mean well, some people attending those meetings may say that if you're taking any drug that has mood-altering properties, you are not "clean." I do not agree with these individuals. In fact, some 40 percent of alcoholics and addicts have a dual diagnosis, meaning they have other clinically apparent psychiatric illnesses such as depression or manic-depression that require medication. Other people might need antidepressants to help lift them from depression and help stop the demons screaming inside their heads.

Further, it may help those who have gotten off addictive drugs to understand that, at some point in their lives, they may have to take controlled substance drugs for medical reasons such as for pain after surgery. This is not a death

sentence, but needs to be treated carefully by the health professional and the patient. The patient should be given no more of the drug than is absolutely necessary. And probably the best thing to do is to treat the experience as if it were a relapse. Assume that the patient will lose control of the decision to use or not to use the drug excessively. In other words, it's a controlled relapse, not a drug-seeking behavior.

Also, if you have a dependency, find a physician who understands addiction. You also need a pharmacist who understands addiction. For example, if you need an over-the-counter cold preparation, the pharmacist can help you choose one that is safer for you.

We need to remember, too, that once someone has been addicted, they're not immune from becoming addicted to other substances. This includes alcohol, even if they've never been alcoholic. It's often tough for people to accept that alcohol is risky. But once they've been addicted to a mood-altering substance and they have the brain chemistry that predisposes them to dependency, they're at risk.

The use of alcohol can lead to drug relapse. Alcohol can lower their inhibitions and they may decide to "use" again. It's also common to switch addictions from pills to alcohol, or vice versa.

Recovering individuals also should know about relapse counseling. This involves teaching the recovering person to recognize the early warning signals of impending relapse. Relapse is not just suddenly picking up a pill and taking it. Relapse is a long path of events; individuals can usually identify the sorts of things that lead them in a downward spiral toward relapse. For example, someone might start feeling anxious and start acting it out sexually, spending money, or being nasty with people. These may be warning signs that they need to get back to support meetings and talk to people. They're starting to isolate, which is a setup for relapse.

Support for Families

For every man or woman who suffers with addiction, at least five or six others are suffering also, often deeply. These are family members and close friends who anguish over seeing a loved one self-destruct with powerful prescription drugs. Addiction is a family disease—it affects everyone in the circle of family and friends. No one escapes the pain and the chaos. All too often, children bear emotional scars for life as a result of being raised in a home with an addicted parent; however, family members can take actions that may help their loved one. And there are actions that family members can take to ease their own pain.

Addiction Affects the Entire Family

All too often, family and friends see the addict as being the only one with the problem. But the drug abuser's behavior takes an emotional toll on everyone around him or her. Without insights and understanding, loved ones also spiral downward, deeper into the addiction trap.

If you have an addict in your family, you already know the pain and despair that addiction brings. Many families are ashamed about having an addict in the family—what will friends and relatives think? Living in the midst of addiction produces a range of other painful emotions—confusion, anxiety, and often depression.

Experts describe addiction as causing a form of "insanity," or emotional chaos, within a family. When the chemical of choice is a prescription drug, this insanity is intensified. Family members are further confused. At first, they believe their loved one must need the drug. Then, gradually, they question the way the addict is abusing the drug. They wonder if the doctor is aware of this abuse. If so, why does the physician continue to prescribe?

Furthermore, these drugs are not coming from a shadowy street dealer—in many cases, they're being prescribed by health professionals. Even though we know the addict is ultimately responsible, the family questions how a health-care system that heals us and saves lives can be the same system administering a drug that contributes to the destruction of their loved one.

The Toll of Addiction

"Drug abuse leads to violence, separation of parents and children, loss of jobs, feelings of hopelessness, serious money problems, single parenthood, anxiety over child-care needs, bad relationships, and emotional and behavioral difficulties in children. Many drug abusers end up in prison or jail. Sometimes they steal property to get money for drugs; or, often, they will commit crimes while 'high' on drugs."

—National Institutes for Health

Enabling the Addict

Those of us who have lived with addiction have seen its ravages in the form of family arguments, ruined holidays, legal problems, job loss, financial problems, traffic tickets, and worse—traffic accidents. Indeed, feeling powerless to stop someone you love from destroying himself or herself is an

extremely painful experience. Many of us, with only the best of intentions, try to help, try to save our loved one from harm's way. But families, operating out of simple love and concern, often do the wrong thing because they do not understand the dynamics of addiction. Families and friends often *enable* the addict. Enabling involves rescuing or doing for someone what he or she should be doing himself or herself.

Levels of Enabling

Family and friends enable anytime they try to minimize the consequences of the addict's behavior. There are two stages of enabling—*innocent* and *desperate*.

In the *innocent phase* of enabling, family members think the person is just going through a little difficulty in his or her life, and so they try to "cover up" the consequences. An example of this might be paying the fine for a traffic accident, rather than addressing the underlying cause of the accident. The enabler may say, "Well, this is our beloved Jeff or our beloved Mary, who can't possibly be an addict like those people who live on the other side of the tracks."

In the *desperate phase,* the family finally realizes, because of the continuing consequences, that a loved one has a true addiction problem. They are so horrified that they actually step up the enabling process because they don't want the worst consequences to come about, such as a family member going to jail or losing a job. So they actually go into high gear enabling the problem, paying rent or paying medical expenses that may arise from the addiction.

Jill's Story
Learning to Not Enable

My twenty-three-year-old daughter Laura had originally been prescribed painkillers for legitimate chronic pain, but she increased the dosages and began a destructive, five-year

bout with addiction. In hindsight, I realize our entire family enabled Laura.

Fortunately, she is in recovery now. I used to say her addiction was like seeing her on a speeding train heading toward a brick wall, and I could do nothing to stop it. It was so painful to see her destroying herself. In the beginning, we tried to help her, but we really were enabling her. For example, on three separate occasions, we set her up in an apartment. We helped her find each apartment and paid the deposits and first month's rent. We always thought Laura would get on her feet and be responsible. But she didn't. When she didn't pay the rent, the landlords would come looking for us.

Laura was a young woman who had never caused us problems or been in trouble. But as an addict, she was a different person altogether. We were exasperated. One doctor told us she was an addict, but we didn't believe it. We knew she needed pain medications, which had been prescribed by a doctor, so we were slow to believe she had an addiction problem.

At one point, Laura's grandmother took her into her home. Laura stole pain pills from her grandfather, who was quite ill at the time. She also caused a lot of damage to the house. She was high on pills and forgot to turn off the water in the bathtub; it overflowed and caused part of the ceiling to collapse. She also stole money from her father and me. One night she ran up a $1,000 phone bill, talking to a "psychic" on a 900 phone line all night. The chaos was ongoing.

Finally, we realized that the more we were helping Laura, the more she was failing. We had to quit supporting her. It was very difficult to stop rescuing her, but we did. However, we did not abandon her. We always told her we loved her, and that she could always call us collect, and that we would always be there to help her when she was ready to get help. We have a strong faith in God, and came to believe that only He could show her the way. Fortunately, she found the way and is now clean and sober.

Today, my advice for other families is not to rescue or enable the addict in your family. Ask yourself: Is what I'm doing helping matters or making them worse? But always let them know you will help them when they're ready to help themselves. Understand that addicts can't recover on their own. It's as if they've fallen into a well with moss-covered sides, and they can't get a grip to pull themselves up. To recover, they must reach out and ask for help. But, until they're ready, always let them know that you love them and that your heart is open.

Detach with Love

So, if it is not constructive to rescue the addict and he or she steadfastly refuses to get into treatment, what can you do? The theory behind the twelve-step support programs is to *detach* from the addict. This doesn't mean you stop loving the person. It doesn't mean abandoning the person or not being supportive if he or she decides to get help. It means "detaching with love" and stopping the game of rescue. The Al-Anon literature says, "detachment is neither kind nor unkind. It does not imply judgment or condemnation of the person or situation from which we are detaching. It is simply a means that allows us to separate ourselves from the adverse effects that another person's addiction can have upon our lives."

Too often, family and friends become obsessed with rescuing the addict. In the process, we teach addicts that they do not have to face the consequences of their actions—we'll be there to "pick up the pieces." As a result, we become "codependents," focused on the lives of the addicts rather than on taking care of ourselves. We succumb to the crises, the chaos, and the heartbreak.

Giving up the role of keeper or rescuer can be difficult, but in the end, we family members must come to the realization that even with all our rescuing, the addict has not changed. We must learn to take care of ourselves and seek help for our own emotional pain at seeing a loved one self-destruct. When family

members get the focus back on themselves, the addict often realizes that the "game" is ending. Sometimes, he or she may give new consideration to taking responsibility for personal behaviors. Still, don't give up on an addict. Let the individual know that you are ready to help when he or she is ready to get help.

Molly's Story
Trying to Save a Marriage

I'm a special education teacher. I finally left my husband about a year ago. I had lived with his addiction to painkillers for nearly fourteen years. I loved him deeply and never wanted to divorce, but I could not allow any more emotional damage to be done to our children or me.

My husband, John, injured his spine in a car accident in 1989, when he was twenty-two. We were married in 1991. He had always had migraine headaches, and after the accident he had them more frequently. He also suffered with pain and eventually had back surgery to insert metal plates in his back. He was taking heavy doses of Demerol for pain. He was so drugged that sometimes he did not know me. He wouldn't be able to speak. He drooled. He is very tall—six foot five inches. At one point, he got down to 180 pounds. He was so skinny he looked like a prisoner of war. I didn't realize the problem was the drugs; I thought he had a problem in his brain. I videotaped his behavior to show his doctors.

We went to various doctors and specialists. At times, he would try to come off the medications, but his pain would be so severe that he would start the painkillers again.

It was about five years into the marriage that I discovered that he was getting additional drugs. I had sensed that something was not right—that there had to be another reason he was so affected by the drugs. I went to various pharmacies and got lists of the drugs he was taking. It turns out he was getting drugs from several doctors. I thought I could put a stop to this by

canceling all our credit card accounts and closing the checking account so he wouldn't be able to buy drugs.

Then, I arranged for him to go to a treatment center. I dropped him off. He didn't even know it was a treatment facility. He stayed fourteen days. He came out sober and with no pain. No migraines. He went out and got a job with a construction company. Up until now, I had been the sole breadwinner. He was doing well. He changed jobs a couple of times, but managed to hold a job for about three years. We had our first child in 1997.

Then, in 1999, when I was eight months pregnant with our second child, I found Demerol in his overnight bag. I flushed them down the toilet. He was very angry with me. He said he was having pain again and that he needed the pain medication. He had gone to other doctors, whom I knew nothing about, to get the drugs.

What was to come was predictable. Soon, his behavior was changing. He was lethargic and was losing his motor control. I took him to a hospital, not totally understanding if he really had pain again or whether he was addicted. A nurse there told me he was addicted, but I defended him, saying he needed the medications for pain. Looking back, I realize I was in denial.

About two months later, he fell off a ladder at work and had to have knee surgery. He got more painkillers. He never went back to work after that. He receives disability income from the state.

As part of my faith, I do not believe in divorce, and I always believed I should not leave him just because he had been injured. This type of thinking kept me stuck for years. I knew deep down he was a good person. I just hoped I would get the real John back some day. I would always make excuses for him about why he didn't participate in family activities. He was so impaired that, eventually, the only task he was responsible for was doing the laundry.

When I finally realized the toll the addiction was taking on my children, I knew I had to leave. They deserved a stable

environment. I finally gave him an ultimatum. I told him that if he didn't change, I was leaving with the kids. I've been gone two years now, and sadly, he hasn't changed. He lives with his mother. My kids are now eight and ten. We have stability in our lives now. They are happier and emotionally healthier. I finally see my husband differently now and I recognize the situation for what it is, but it took me a long time to get to that point.

Advice to Others: Don't discredit your own needs and tell yourself you're trying to help your addicted spouse. I thought I was helping John, but I was enabling him and all the while hurting myself and my children. I'll always remember the advice a therapist gave me. She said, "You can hope and pray that your husband recovers, but make decisions as though he never will."

Ten Ways a Family Members Can Help a Loved One with a Drug Problem

1. **Learn the facts about alcoholism and drug addiction.** Obtain information through counseling and/or open meetings of Alcoholics Anonymous or Narcotics Anonymous. Addiction thrives in an environment of ignorance and denial. Only when we understand the characteristics and dynamics of addiction can we begin to respond to its symptoms more effectively. Realizing that addiction is a progressive disease will assist family members to accept their loved one as having a disease rather than being a bad person. This comprehension goes a long way toward helping overcome the associated shame and guilt. No one is to blame.

   The problem is not caused by bad parenting or by any other family shortcoming. Attending an open Alcoholics Anonymous or Narcotics Anonymous meeting is important. You can also seek out family-support programs such as Al-Anon or Nar-Anon.

These support groups help families see that they are not alone in their experience—that there are many other families involved in this struggle. Families will find a reason to be hopeful when they hear the riveting stories of recovery shared at these meetings.

2. **Don't rescue the alcoholic or addict. Let them experience the full consequence of their disease.** Unfortunately, it is extremely rare for anyone to be "loved" into recovery. Recovering people experience a "hitting bottom." This implies an accumulation of negative consequences related to drinking or drug use, which provides the necessary motivation and inspiration to initiate a recovery effort. It has been said that "truth" and "consequences" are the foundations of insight, and this holds true for addiction. Rescuing addicted persons from their consequences only ensures that more consequences must occur before the need for recovery is realized.

3. **Don't support the addiction by financially supporting the alcoholic or addict.** Money is the lifeblood of addiction. Financial support can be provided in many ways, and they all serve to prolong the arrival of consequences. Buying groceries, paying for a car repair, loaning money, paying rent, and paying court fines are all examples of contributing to the continuation of alcohol or drug use. Family members with the best of intentions almost always give money, but it always serves to enable the alcoholic or addict to avoid the natural and necessary consequences of addiction. Many addicts recover simply because they could not get money to buy drugs. Consequently, they experience withdrawal symptoms and often seek help.

4. **Don't analyze the loved one's drinking or drug use. Don't try to figure it out or look for underlying causes.** There are no underlying causes. Addiction is a disease. Looking for underlying causes is a

waste of time and energy and usually ends up with some type of blame focused on the family or others. This "paralysis by analysis" is a common manipulation by the disease of addiction that distracts everyone from the important issue of the illness itself.

5. **Don't make idle threats. Say what you mean, and mean what you say.** Words only marginally impact the alcoholic or addict. Actions speak louder than words when it comes to addiction. Threats are as meaningless as the promises made by the addicted person.

6. **Don't extract promises. A person with an addiction cannot keep promises.** This is not because they don't intend to, but rather because they are powerless to consistently act upon their commitments. Extracting a promise is a waste of time and only serves to increase the anger toward the loved one.

7. **Don't preach or lecture. The addicted person easily discounts preaching and lecturing.** A sick person is not motivated to take positive action through guilt or intimidation. If an alcoholic or addict could be "talked into" getting sober, many more people would get sober.

8. **Avoid the reactions of pity and anger. These emotions create a painful rollercoaster ride for the loved one.** The level of anger you feel toward an addicted loved one will be replaced by the same level (or more) of pity for the loved one once your anger subsides. This teeter-totter is a common experience for family members—they get angry over a situation, make threats or initiate consequences, and then backtrack from those decisions once the anger fades and is replaced by pity. The family then does not follow through on their decision not to enable.

9. **Don't accommodate the disease.** Addiction is a subtle foe. It will infiltrate a family's home, lifestyle, and attitudes in ways that can go unnoticed by the family. As the disease progresses within the family system, the family will unknowingly accommodate its presence. Examples of accommodation include locking up valuables, not inviting guests for fear that the alcoholic or addict might embarrass them, adjusting one's work schedule to be home with the addict or alcoholic, and planning one's day around events involving the alcoholic or addict. (A spouse confided that she would set her alarm to get up and pick her husband up from the bar.)

10. **Focus on your life and responsibilities.** Family members must identify areas of their lives that have been neglected due to their focus on, or even obsession with, the addict or alcoholic. Other family members, hobbies, job, and health, for example, often take a backseat to the needs of the addict or alcoholic and the inevitable crisis of addiction. Turning attention away from the addict and focusing on other personal areas of one's life is empowering and helpful to all concerned.

Source: Ed Hughes, Executive Director, The Counseling Center Inc., www.thecounselingcenter.org.

What Is a Family Intervention?

In the best-case scenario, the one who's struggling with addiction will decide to seek treatment, but this doesn't always happen. In this case, you may wish to consider an *intervention*. An intervention is a planned event in which the person who is chemically dependent is confronted by family and friends in an effort to get him or her into treatment immediately. An intervention may be informal or structured.

Informal Intervention

In an *informal intervention,* a family member or friend, or possibly a therapist acting on behalf of the family, may confront the individual. Bruce Cotter is a professional interventionist who works with addicts on a one-to-one basis. Having done interventions in which a group confronts an individual, he now prefers to work alone. "People I work with are scared, angry, confused, and paranoid. They're despairing, they're hurting, and they feel guilty. So, I find I can work more effectively with them alone, rather than confronting them with a group."

Cotter cites an example of working with a young man, Robert, from the Midwest. "When I met with the family, I could see how angry they were at their son. I don't think it would have been good to have them there for the intervention. Instead, I met alone with him at 6 o'clock in the morning at a motel. We sat and talked for almost three hours. He spit out a lot of stuff that he wanted to say, that he probably never would have stated in front of his family. Plus, I have credentials as a therapist, but I'm also a recovering addict, so I could assure Robert that I knew what he was going through."

In the course of working with an individual, Cotter wants the addict to *choose* treatment, not be talked into it. "The worst thing you can do is tell an addict what to do. They won't buy it. I want them to make the decision to seek treatment and then I support their decision. They already know they don't want to continue living the way they are, but they are afraid of giving up their drug of choice."

When Cotter is hired to do an intervention, he accompanies an individual to the treatment center. He has all transportation arranged—cars and plane tickets if necessary. He stays with the patient throughout the admission process at the treatment center. Then, a couple of weeks later, Cotter returns to the treatment center to check on the patient and offer his continued support. He also designs an aftercare program of

support to be implemented upon the patient's release from a treatment center.

Cotter's services represent one style of informal intervention. If your budget won't cover such extensive involvement, including travel, help is still available. Many therapists and interventionists offer a range of services that may be tailored to fit your needs and budget.

Structured Intervention

A *structured intervention* involves family and friends, and sometimes a counselor. In either case, if the meeting concludes successfully, the individual is driven directly to the waiting treatment facility.

The intervention team is commonly made up of a group of three to eight family members and friends. Each team member needs to make a commitment to learn about the dynamics of addiction and how to intervene properly. This is important since each family member and friend usually has a different idea of what is right. It often helps to have a professional interventionist or therapist help plan and carry out the intervention.

Organizing the Intervention Team

Once assembled, the intervention team can discuss in detail their experiences of the negative consequences with the addict. This is often an eye-opening process because different family members and friends will have had different experiences with the addict; it may be quite a revelation to them to realize how they were involved in enabling. The team should also choose a chairperson and a "detail person," someone who will take care of all the little things about getting ready to get the addict into treatment.

Taking Care of Details

The team members need to plan ways to counter each objection the addict may have about entering treatment. "They need to be prepared for such objections as 'I can't take

time off from my job,' in which case the family will have already talked to the employer in advance, without the addicts knowledge," states Jeff Jay, an interventionist and coauthor of *Love First: A New Approach to Intervention for Alcoholism and Drug Addiction*.

For someone who lives alone, the objection to going into treatment might be, "Who's going to take care of my dog?" It's important that the team has excellent answers to these objections. According to Jay, "You will never see an addict who is more shocked than when a team member says to him, 'We know how much your dog Spot likes Uncle Roger, and Roger has agreed to take Spot while you're in treatment. In fact, we're ready to take him over to Roger's house right now.' This kind of preparedness usually causes the addict's jaw to drop. They're saying to themselves, 'These people have thought of everything! Now is the time for me to get help.' "

Another important matter is to determine what treatment center the person will be going to. Will insurance cover it or not? The detail person needs to keep track of all this.

Carrying Out the Intervention

When the actual intervention takes place, experts say it's best to have it in a place outside the addict's home. The home of a team member is a good choice. Intervention should be done only when the person is sober, so this often means doing it early in the morning. "It's important to have the most important people in their life there. For example, if it's an adult male, I often try to have his mother walk right up to him, give him a hug, and say, 'Honey, we need to talk.' She may guide him over to the couch and everybody sits down," explains Jay.

He also recommends that the intervention be very tightly scripted, so rather than having people talk off the top of their heads, they actually take turns reading a letter to the addict. "I like to see the letters open up with very loving statements, which is often very surprising to the addict. This is a 180-degree difference from what they're expecting to hear.

When the intervention is taking place, the last thing that the addict expects to hear is people telling them what a great person they are and how important they've been in that person's life. They expect to be beaten over the head. So what we do is, we put a different twist on it and this kind of destabilizes the addict and gets them ready to hear more.

Setting Up an Intervention

Interventions must be well organized. You may be able to find a therapist, who has experience with interventions, to help your family. You can also go online and find professional intervention services that will send an interventionist to you.

"For example, a letter to me when I was in my addiction was, 'Dear Jeff: I love you, I care about you, and when I was going through a divorce five years ago, you were the one who was there for me. You're the one I could always count on to speak to, and you gave me such good counsel and support that I couldn't have made it without you. Now I see that you're going through difficulty and I am going to be there for you.' After they tell the addict how important they've been, their letter can explain, 'Ive taken some time to learn about alcoholism and drug addiction, and I understand that you have a medical problem. It's not a character issue. It's not a willpower issue. It's really a medical issue and I want you to get medical help for it.' "

Next in their letters, the intervention group should move into a "fact reporting" phase in which they list the reasons why the addiction is causing problems. This should include no judgment, no blame, no anger. Just the facts. Then, in closing their letters, each member can reiterate love and concern and ask the addict to get treatment at a very specific treatment center right now. Today.

Joni's Story
A Brother's Intervention

I felt we had to do something to help my brother Jerry, age 40, with his addiction. I knew I would always feel bad if we didn't try. I organized a team of ten of us, including family, friends, and colleagues. We prepared for about two months. I read everything I could find about interventions. We also hired a professional interventionist to guide us.

The day we did the intervention, Jerry was invited to a friend's house, where we were all waiting. He was rather shocked to see us all there, especially since several of us had flown in from out of town. But, the second he saw us, he knew what was up. He was angry at first, but we'd all been told to expect this, so we did not let his anger dissuade us. We all talked to him, telling him how his addiction had affected him and us; we also stressed how much we loved him and wanted him well.

He tried to make an excuse—that he had to go home and pack. We told him his suitcase had already been packed by his wife; she had brought it over ahead of time. When he insisted that he be able to go home and shower, my other brother went with him. He asked us, "Are you afraid I'll run?" We all said, "Yes." He took a shower, returned, and my other brother and I took him to the treatment center. He completed treatment and has remained in recovery for several years now.

Looking back, I feel really good about what we did. We helped save his life. So, we had a good outcome, but it wasn't easy. It was a very emotionally taxing experience. It was scary, too, because we didn't know if we would succeed.

My advice to others who are considering an intervention: Do it. You will always know you tried. I also suggest educating yourself about interventions and being well organized. It's good to have the help of an interventionist or a counselor who understands how interventions are carried out and can guide you. These professionals can be objective, less emotional, whereas we family members are very emotional and not objective.

Paula's Story

Getting Help for Yourself

I lost my 28-year-old brother, Ray, to his drug addiction. He abused painkillers for years and ultimately died of an accidental overdose. My family really tried to help him, but in hindsight I realize that we were not informed about addiction. For example, I didn't know that it would be very difficult for him to quit drugs cold turkey. I also thought he took pills because he just liked getting high. In reality, of course, he was using pills to numb emotional pain.

I remember trying to help in ways that didn't help. For instance, I called more than one of his doctors to report that he was abusing the drugs they had prescribed. But as you might guess, my calls had no effect on the real problem. Another time, my parents and I even went to court and tried to have my brother committed to a treatment center; however, the law required us to prove that he was mentally ill and dangerous, which we could not prove. The judge dismissed the case, and my brother was furious with us, further inflaming the family ties.

Yet another time, we tried to convince Ray to voluntarily enter a treatment facility. My parents and I were willing to cover the costs. He reluctantly agreed to visit the treatment center with us. Once there, we spoke with a social worker. Ray was high on pills at the time of the visit and was belligerent to say the least. Finally, when we realized he would not agree to entering the rehab program, I recall the social worker telling us, "Go to a family support meeting such as Al-Anon or Nar-Anon, the sister organization to Narcotics Anonymous. If he won't get help for himself, get help for yourself."

I dismissed the suggestion, saying to myself that my brother was the one with the problem—not us. In hindsight, I realize how much we could have benefited from support. We needed help in coping with our own emotional pain and perhaps we could have learned about addiction and ways we might have been able to better help Ray.

Taking Care of Yourself

Interventions work well for many families. However, they don't always result in a loved one getting treatment. Remember that addiction is a progressive disease—it gets worse if it is not brought under control. So, if your loved one will not agree to get professional help, get help for yourself. You're hurting, too. Seek emotional support. Consider finding a therapist in your area who is experienced in addiction issues, and look into support groups, such as Nar-Anon for families. Learn all you can about addiction. The more educated you are, the more prepared you'll be to help your loved yourself and your loved one.

Pain Management and Addiction

It is estimated that 20 percent of Americans suffer from chronic pain. Nearly three-fourths of this group report that pain interferes with daily activities, and about two-thirds of those with chronic pain take pain medication daily. The major causes of pain are headaches, back pain, arthritis, and cancer. Many causes of pain are related to aging, and most chronic pain sufferers are middle age or older.

Most people who are using painkillers for legitimate pain are using their medications as directed. However, those who abuse narcotic painkillers make up the largest group of prescription drug abusers in the United States. Between 1992 and 2002, prescriptions for pain pills increased 222 percent.

Risk of Addiction from Pain Treatment

According to the American Pain Society, the incidence of addiction is 3 percent among patients who are treated for legitimate chronic pain and have no history of drug abuse; these are patients who use pain medications as directed and who are evaluated regularly by their prescribing physicians. According to the study, these patients are using medications to ease their pain rather than to alter their mood.

However, some pain specialists say that they see a great number of people who are taking opioids for pain and become addicted. Edward Covington, M.D., is a pain specialist at the Cleveland Clinic. "In our chronic pain rehabilitation program, a little over 30 percent have an active addictive disorder."

From Treatment to Addiction

How do legitimate pain patients get themselves into trouble with pain medications? Problems may occur if patients are not honest with themselves and their physician. For example, a problem with addiction may arise if a patient's chronic pain still exists, but he or she starts using opioids to treat new or preexisting problems with anxiety, depression, sleep disorders, or adverse social or economic problems.

Other warning signs that you may be abusing pain medications include:

- You increase the number of pills you take.
- You go to different doctors to get more drugs.
- You mix alcohol with drugs to increase their effect.
- Your loved ones start expressing concern over your use of painkillers.

It's important for patients to keep their doctors informed of any of these warning signs. The physician may be able to help a patient avoid sliding deeper into addiction. For example, the patient may need help with coping skills and can be referred to a therapist. Or, the patient may need other medications that are nonopioid. In the case of depression, antidepressants would be the preferred medication rather than having the patient take increased doses of opioids.

Q & A with Pain Specialist Edward Covington, M.D.

Pain specialists are neurologists, physiologists, psychiatrists, nurses, and other specialists who are trained in pain management. According to pain specialists, treating chronic, nonmalignant pain can be complicated because the needs of those who suffer with it are diverse.

- **What type of patients do you see as a pain specialist?** Most patients who see pain specialists are those who have chronic, non-cancer-related pain. Probably over 60 percent have spine-related pain. The second most common pain I see is that from fibromyalgia or migraine headaches. The third largest group would be those with pain from arthritis or nerve damage.

- **What do you do when a pain patient becomes addicted?** Well, first, we don't withhold pain treatment from someone who has become addicted; however, we try to encourage the person to get into recovery. If you have an active addiction disorder and a chronic pain problem, probably anything we do for the person will fail until the addiction is brought under control.

  Keep in mind, we do see a condition known as "pseudo-addiction." This involves a situation in which a person is not receiving enough opioids for their pain and they exhibit "drug behavior," much like an addict. However, once we treat them with additional opioids, they become perfectly normal patients and do fine.

- **What should people do if they need surgery and pain management, but they are in recovery from addiction to alcohol or pain pills?** First, the patient should tell his or her surgeon and anesthesiologist about their history of addiction. After surgery, the surgeon should wean the patient off painkillers as soon as possible. We also encourage these patients to attend recovery meetings.

  We may suggest that the patient give their painkillers to

a spouse or a relative, instructing them to give the patient their medications and give them only as directed. It's not right to ask a person in recovery to walk around all day with a bottle of Percocets in his pocket. I don't think I have seen an addict in recovery fail at managing postoperative pain when they developed a strategy with their doctors. The problem arises when the patient keeps their drug abuse a secret from the doctor; this may lead to doctor shopping or acquiring more drugs illegally.

- **Do you think doctors should have pain patients sign "pain contracts"?** Yes, they should. A pain contract shows that the patient has been told about the risks of addiction. This makes the patient more aware of potential risk, and it usually frees the doctor up to treat the pain more aggressively since he or she knows that the patient has been informed.

  A contract also informs the patient of side effects. And a pain contract gives the doctor the right to speak to family members and pharmacists. A family member may have a better sense of when someone is abusing opioids than the patient does.

- **How can pain patients monitor themselves to help prevent them from sliding into addiction?** The simplest thing people can do is remind themselves that an addictive disorder is a disease, and a disease does not make you get well. If you're taking opioids and your pain is less and your function is better, chances are good that you're not in trouble. However, if you've increased your dosages, you're still having pain, and you have a poor degree of function, then it's likely that the opioids have become more of a liability than an asset.

  There are other signals, too. You might be in trouble if you find yourself preoccupied with your pills, you can't seem to control how many you take, and you run out of them early. And of course, if you take increased dosages and continue to do so in spite of the problems it brings

into your life, you have probably developed an addictive disorder.

- **What should a person do if his or her pain persists?** Many people are told that nothing more can be done for their pain, but this is not always the case. Chronic pain rehabilitation programs are not plentiful (there are about 3,000 pain specialists in the United States), but if you can find one, they can often help. In fact, pain clinics have a pretty high rate of success. Don't give up. Try a pain rehabilitation program.

Pain Is Often Undertreated

In spite of the growing public awareness that pain pills are highly abused in the United States, the fact is that legitimate pain is often undertreated. Federal guidelines estimate that as many as half of the millions of people who have surgery annually receive inadequate pain management for postsurgical pain. It's also estimated that as many as 80 percent of cancer patients do not receive adequate medication for pain.

Fear of Addiction

One of the main barriers to effective pain management is fear of addiction—by both patients and health professionals. "In the past few years we've tried to focus on improving pain management because we know that for the past several decades pain has not been well controlled," states Betty R. Ferrell, R.N., Ph.D., an associate research scientist on pain management at City of Hope National Medical Center, Duarte, California. "When we see patients who are afraid to take the pain medication, we explain the difference between drug addiction and physiological dependence. In the latter case, if the patient should eventually come off the pain medication, it would be done gradually with medical supervision; otherwise, the patient would have withdrawal."

High-profile cases also create myths about addiction, explains Ferrell. "When we hear about a celebrity who's addicted to prescription drugs, we think we're all candidates for such addiction; however, these celebrities often have a history of alcoholism or addiction. And it is those patients who do have a history of substance abuse who can become addicted to their medication."

Undereducated Physicians

Studies indicate that medical students lack pain management training. In one study, reported by the *Journal of the American Board of Family Practice*, 88 percent of the doctors surveyed stated that their training in pain management was poor. Seventy-three percent stated their residency training was fair or poor.

To avoid problems with addiction, pain management experts stress the importance of proper evaluation of patients; such evaluation may determine whether a patient has underlying emotional problems (such as depression or anxiety) that may predispose him or her to escalating doses and becoming addicted. Experts also stress the importance of continued reevaluation of patients to detect signs of addiction.

Doctors' Concerns about Being Investigated

Creating public awareness about the abuse of prescription drugs, especially painkillers, creates serious concerns for health professionals who deal in pain management. Media coverage about the abuse of painkillers may cause doctors to decrease the amount of painkillers they prescribe. Doctors often have concerns that they may come under scrutiny and their medical licenses may be at risk if they appear to be prescribing too many controlled substances, even though some patients may need ongoing, high dosages of painkillers to combat pain.

"Reluctance to prescribe opioids for intractable pain can often be attributed to physicians' perceptions that they will be investigated for violation of laws governing controlled substances," states David Joranson, senior scientist and

director for policy studies with the Pain Research Group at the University of Wisconsin. "These laws and regulations amount to legal barriers to pain management. The medical use of controlled substances can provide great improvements in the quality of life for millions of people with debilitating medical conditions."

Joranson acknowledges the need for diversion control; however, he also stresses the importance of not restricting legitimate patients' access to narcotics for pain. "It is essential that we evaluate the barriers to effective pain relief. It's important to understand that opioid analgesics are the mainstay in the treatment of acute pain. Consumers should talk to caregivers if pain is not being treated sufficiently."

Pain Is Treatable

An important thing for consumers to know is this: Pain relief is available. Widely accepted medical treatment for cancer pain shows a success rate of 70 to 90 percent, if a patient's physician follows a standard, accepted guideline for pain control. Similarly, if appropriate guidelines are followed for the treatment of acute pain, such as postoperative pain in hospital settings, the success rate for treatment is 90 to 95 percent. As mentioned earlier, if a patient has any concerns that he or she is losing control and becoming addicted, the patient needs to be honest about this with his or her physician.

Barriers to Effective Pain Management

Problems Related to Patients

- Reluctance to report pain
- Concern about distracting physicians from treatment of the underlying disease
- Fear that pain means the disease is worse
- Concern about not being a “good” patient
- Reluctance to take pain medications
- Fear of addiction or being thought of as an addict
- Worries about unmanageable side effects
- Concern about becoming tolerant to pain medications

Problems Related to Health Professionals

- Inadequate knowledge of pain management
- Poor assessment of pain
- Concern about regulation of controlled substances
- Fear of patient addiction
- Concern about side effects of analgesics
- Concern about patients becoming tolerant to analgesics

Problems Related to the Health-Care System

- Low priority given to cancer pain treatment
- Inadequate reimbursement
- Restrictive regulation of controlled substances
- Availability of treatment or access to treatment