# CHRONIC PAIN AND ADDICTION ITS IMPACT ON FAMILIES

By Claudia Black, PhD and Mel Pohl, MD

Pain is universal and important to all beings—it is a warning that something is wrong and needs attention to prevent further damage to the body. Whereas acute pain protects the body while it heals from trauma or injury, chronic pain is simply ongoing, persisting beyond its usefulness.

People commonly react by resisting the pain—tightening muscles, stiffening posture or trying to avoid movement. Resistance causes anxiety, sadness, fear, anger and frustration; and the more resistance, the worse the pain and suffering. Chronic pain includes the physical pain coupled with the emotional pain (suffering), triggered in the brain and generated by the limbic system (the emotional center of the brain). Physical pain and emotional pain are equally real.

As our population ages, chronic pain and its costs—both financial and on a human level—are increasing. Today, medical systems treat chronic pain in over 70 million Americans with a methodology known as "pain management," which typically includes medications and procedures, such as injections and surgeries. The estimated annual cost of chronic pain treatment in the U.S. is $100 billion. The longer we live, the more likely we are to develop pain from a variety of conditions: autoimmune disorders, diabetes, arthritis, cancer, etc. Every time there is a car accident or a sports injury, someone is set up for chronic pain. Furthermore, in the case of back pain, research suggests that obesity, depression and/or increased awareness of the condition contribute to an increase in back pain (Griffin, 2009).

Chronic pain syndrome is characterized by:

- intractable pain lasting longer than six months;
- marked alteration of behavior;
- depression or anxiety;
- marked restriction in daily activities;
- excessive use of medications and medical services;
- no clear relationship to organic disorder; and
- multiple, non-productive tests, treatments and surgeries.

## Drugs and chronic pain

Addiction treatment professionals will see the similarities and the relationship of addiction to chronic pain, both of which: involve feelings and loss of control; affect personality; are characterized by preoccupation, rationalization and denial; and have a profound effect on those around them. If medications are used for chronic pain, it is not uncommon for dependence and compulsive use to occur, especially with opioid painkillers. People with chronic pain often end up medicating their anxiety, fear, anger and depression with these same drugs, and often have difficulty differentiating physical from emotional pain.

*Christine, who struggled with chronic pain from migraines for several years, repetitively commented, "It just hurts, and I want relief." This was her rationale for continuing to use her drugs. But she had developed dependence, loss of control and compulsive use—in other words, addiction.*

## Families and chronic pain

With the co-occurring disorders of pain and addiction, the treatment of each becomes much more complicated. Living with someone in chronic pain also has many similarities to living with someone with an untreated addiction.

The problems for families are more diffuse and life-altering than those of the person living with the pain itself. The family suffers along with the person in pain, developing their own dysfunctional symptoms, and they need to find strategies and solutions that allow them to cope in more self-enhancing ways. Just as addiction is insidious, the role of pain in a person's life also is insidious. In time, for those within the family's intimate circle, the pain becomes the central organizing feature of the relationship. Everyone is fixated on and responding to the pain. Families often need to make adjustments to accommodate both the person in pain and the results of the pain. They have myriad feelings depending on their relationship and role, and those feelings ultimately drive the highly enmeshed family members to frustration, anger and social isolation.

*Kevin was in a severe sports accident as a teenager, which led to several surgeries and chronic back pain. Kevin's father, now divorced from his mother and remarried with much younger children, is blatantly angry with Kevin. He is angry at Kevin for not working and for making excuses for not working. He is tired of hearing how his son's life has been ruined by the accident and tired of calls from his ex-wife about Kevin's escapades. The latest problem is that she wants him to pay for drug rehab treatment because now Kevin has become addicted to drugs and his behavior is out of control—all related to the accident and what his dad calls "this so-called chronic pain." Kevin feels victimized by his father and the chronic pain and views his mother as his only ally. He also feels entitled, "After all, look what happened to me." Kevin's mother is totally preoccupied with his life and problems, and in turn, views Kevin as a victim because of these horrible things happening to him. She is unable to set any limitations on his behavior, regardless of how upsetting it is to her and the family. His dad is lost in anger and blame, both of which are equally ineffective vehicles for improving his son's life.*

*Bill's wife Eleanor, who suffers from chronic pain—originally emanating from scoliosis surgery, and more recently with a diagnosis of fibromyalgia—has spent 20 hours a day in bed for nearly four years. Bill handles her medical appointments, dispenses her medications and mediates contact with family members. He feeds her, ensures that she is somewhat comfortable, and takes care of all household duties, such as cleaning and laundry, in addition to working full-time. When the decision is made for Eleanor to enter a chronic pain treatment program, he is beside himself. Fearful of being without her, he calls or e-mails staff several times every day to find out when she will be home. In effect, he is going through his own form of withdrawal from Eleanor in this highly enmeshed and dysfunctional relationship. Both these families are reacting to the many ramifications and complexities of having a family member in chronic pain.*

The family is a complex organism, with diverse parts making up the whole. It functions best when all the

different elements are in good working order. When one member is in pain, the equilibrium of the family shifts, and family members change, adjust and accommodate in response to the strain on the family system. This is understandable, however, in time, even if someone has a strong sense of self and worth, the concerned other finds him- or herself acting out self-defeating behaviors.

Families need to develop an understanding of the consequences of their emotional and behavioral responses that may be impeding healthy family function. As an alternative, they need to develop positive coping and relational skills. Often, families may benefit from time apart (which treatment affords) so the person with chronic pain can improve and the family has some breathing room to do work on their own recovery and their healing process.

## Biology of caring

Neuroscience has done much to help us understand what occurs in the brain of the addict, and now it also offers us a better understanding of what occurs for family members. The brain is wired to react empathetically to someone in pain in order to warn others of danger and elicit help. Functional MRI scans show that when watching someone undergo electric shock, the observer's brain lights up in the same areas in which the brain of the person in pain lights up (Bufalari et al., 2007). One doesn't have to witness the painful experience for the brain to react, simply seeing a person act as if he or she is in pain causes the brain to light up. When the person in pain is a family member, the reaction to his or her pain is exponentially stronger.

In another study, when researchers delivered electric shocks to people with chronic pain, they found that in the presence of a solicitous spouse, pain levels and brain activity increased substantially. This study suggests that even though well-intentioned, when a caring person is present, the pain is reinforced (Flor et al., 2002).

## Lessons for family members:

- You are suffering as you witness your family member suffer, but your concerned and doting manner causes more pain in the very person you want to help.
- This research implies that family connections may well be the biological basis for enabling a loved one in chronic pain.
- Treatment implications involve developing a sense of equilibrium despite another's experience of pain.

## Fundamental therapeutic issues for family treatment

***Chronic loss***. To be in a relationship with a person in chronic pain results in multiple losses. There is the loss of the relationship as it once was, loss of shared social and recreational opportunities, loss of financial security, loss of hopes and dreams being fulfilled, and loss of sexual satisfaction and intimacy, to name a few. With these losses come a multitude of feelings:

- Fear that he or she will not get any better
- Fear of financial ruin (e.g., bankruptcy, poverty)
- Fear that your life is over
- Anger for thinking he or she is not trying hard enough
- Anger for what happened to cause this (e.g., God, the drunk driver who was responsible for the accident)
- Anger with the medical system for not having the answers
- Anger at the doctors for creating and perpetuating the addiction
- Anger at insurance companies for denying procedures and holding up the approval processes
- Anger at friends or family for not being there to help
- Embarrassment for his or her behavior when overmedicated
- Guilt for being angry
- Guilt for not being able to do more to make a difference
- Guilt for wanting out of the relationship and feeling trapped
- Sadness for the lost social times
- Loneliness that comes with social isolation
- Loneliness because of the emotional disconnection as he or she is preoccupied, distant, medicated

Understandably, family members often feel guilty just for having these feelings, knowing that the pain is not willful behavior. Their reluctance to express their feelings reinforces the dysfunctional family "Don't talk" rule. In family systems in pain, people learn

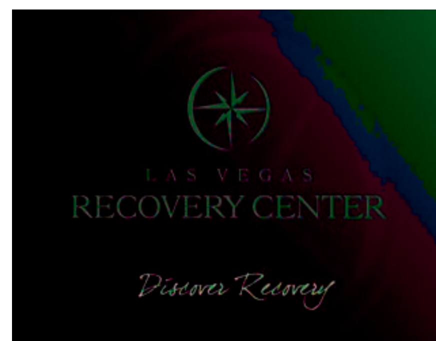
to minimize, discount and deny their feelings. So what do they do with all of those feelings? They learn to stuff them, reinforcing another dysfunctional family rule, “Don’t feel,” which culminates in being stuck in a perpetual, unresolved grief process. Consequently, as with addiction, and to an even greater extent, family members become increasingly more emotionally isolated, not sharing their thoughts and feelings with others.

In addition to the emotional disconnection, they are increasingly socially isolated. They become restricted to the home, not wanting to leave the person in pain for fear that he or she will need them or fear that he or she will put the house or someone else in jeopardy due to being under the influence of drugs. They become the caregiver, nurse, chef and parent—their lives consumed with telephone calls, medical appointments and wading through paper work. They limit people visiting for a host of reasons, such as not wanting to face the questions visitors ask, or not knowing to what degree the person in pain will be overmedicated on any given day.

***Chronic caregiving/perfect helper***. It is only natural to do what is necessary to help when seeing a loved one in pain, but the role of caregiver often becomes overwhelming and burdensome. Sometimes, efforts to make things better actually make them worse. The primary caregiver becomes the insurance expert and patient advocate, running interference with major medical systems and other family and friends, and often takes on a nurse-like role, controlling the dispensing of medication. When this continues for years, it often becomes the caregiver’s primary source of identity and esteem. The consequence of accepting such a role is the essence of codependency: becoming selfless in the service to another. The caregiver no longer acknowledges his of her own needs and wants, abandoning his or her own desires. In the process of being a good caregiver, self-care is forgotten. The ultimate consequences for such a lifestyle encompass the unhealthy expression of anger, martyrdom, sacrificing one’s needs to the needs of another, believing there are no options, and feeling helpless to create change in your own life. Without support and clarity about what is happening, caregivers can ultimately spiral into their own depression or find themselves self-medicating with food, alcohol, and/or other drugs.

***Distorted Boundaries.*** Feeling sorrow and pity for someone in pain, families often take on responsibilities for that person, when in fact he or she is capable of managing those responsibilities independently. This not only creates an unhealthy dependency, it creates a disparate relationship and doesn’t allow the person in pain the opportunity to maintain self-accountability. Enmeshment is extremely common, fueled by feelings of guilt (often false guilt) and fear. Consequently, family members of people in pain act on their behalf, not allowing them to act for themselves.

*Kevin and his mother were so used to her taking care of his needs, that he had become virtually helpless.She acted from a place of sympathy rather than empathy, which only reinforced Kevin’s helplessness. Engaging in empathy rather than sympathy will allow Kevin to maintain a stronger sense of self.*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***High Tolerance for Inappropriate Behavior***. People who are in pain and on various medications frequently express anger in hurtful ways. They feel frustrated, helpless and scared.

*Kevin's family members are experiencing these emotions, but also want to be empathic with Kevin. As a result, they have developed a high tolerance for inappropriate behavior. They are often raged at, called names and treated with hostility. In spite of Kevin's physical limitations, family members were also physically abused by him when he would throw objects at them. They made excuses for his behavior and developed a level of tolerance that had disastrous results, including Kevin's dad ending up hospitalized for a bleeding ulcer. The belief that Kevin's pain means he can't help himself only leads to an abnormally high tolerance for inappropriate behavior. This allows Kevin to become an offender, and his family to move into a victim/martyr role. "After all, poor Kevin is in pain—who am I to complain because he shouts every once in a while? I can take it since I'm the healthy one." Lacking healthy boundaries, Kevin and his parents are using faulty judgment and in danger of making poor decisions.*

***Preoccupation***. As helpless as family members feel about the pain, they often become highly vigilant and preoccupied with the pain and with the person in pain, who becomes the central force in their lives. The family members come to faulty conclusions based on assumptions and inadequate information. They are practicing mindreading, which frequently leads to misinterpretation of the truth. For example:

- *When Bill's wife says, "You go, I'll be fine," that must mean she wants him to stay home with her.*
- *When she rolls over in bed that must mean the pain is worse and she needs more medications.*
- *When Kevin doesn't say he feels better that must mean he's ready to have another temper tantrum.*

The preoccupation with the pain and the person in pain also leads to social and emotional isolation.

*When Bill is with others he cannot focus on connection, let alone have fun, because he is consumed with not being present for Eleanor. Bill talks himself out of being with others so he can stay vigilant, believing Eleanor is incapable of managing for herself. He even started working from home so he could keep an eye on her, not satisfied with his daughters' offers to help him.*

***Controlling behavior.*** In an effort to bring stability to what is a fragile situation, family members become controlling and preoccupied by trying to read everything they can find about the problem, searching out all possible remedies. While there is no doubt that everyone needs advocates within the healthcare system, in time this became Bill's identity and only focus, negating all other needs. Eleanor had cause to be more dependent; for Bill there is a fine line between trying to be helpful and taking over. Controlling behavior is having things done your way, in your time frame, without respect for other people's needs and boundaries. It is created by a fear (an often unrealistic fear) of imminent disaster, and then it feeds on itself. This controlling behavior is demonstrated not just toward the person in pain, but also toward healthcare providers, other family members and all aspects of life. The chronic pain has become the central feature of the family member's life.

***Secondary gain.*** Preoccupation of this type is also very connected to secondary gain. Family members frequently, consciously or unconsciously, sabotage recovery by being attached to their identity within the caregiving role. It becomes the major source of their identity and esteem, and without it they don't feel of value. They feel displaced. They may have found a power in such responsibility and are left with a sense of worthlessness when they don't get to operate in that role. While recovery may be consciously desired, the human element of "but what about me?" needs to be acknowledged and addressed.

*Bill's identity and worth is totally attached to attending to Eleanor's needs. Likewise Kevin's mom relies on her relationship with Kevin for the meaning in her life. As Kevin and Eleanor get well and more independent, Kevin's mother and Eleanor's husband find their sense of self falters, requiring them to rediscover their own lives. As Kevin improves and becomes more accountable for his actions, his father loses the primary focus of his deep-seated anger, which stemmed in large part from his own issues of an abusive childhood. Having more clarity about his feelings enables him to respond in a healthier manner to the present reality.*

## Treatment goals

Successful treatment must include family members. Similar to any effective treatment for codependency, clinicians should consider the following when working with families:

1. Offer a framework to understand the differences between emotional and physical pain.
2. Validate that all pain is real.
3. Validate the experience of loss.
4. Help family members decrease their isolation.

5. Help family members recognize codependent behaviors as self-defeating to both themselves and their partner/family member in the long run.
6. Offer them a framework to understand the basis of their codependency.
7. Assess for primary disorders, including pain, addiction, and psychiatric co-morbidities.
8. Assist them to engage in greater self-care practices and establish their own program of recovery.

Throughout this process it is critical to help the client and family members discuss their hopes and expectations. Expectations are many times simply fantasy—the expectation that there will be instant intimacy, healthy communication and no conflicts. Counselors should remind families that they are not performing "brain transplants" in treatment; rather, they are simply eliminating toxic substances and helping clients' change their patterns of thinking, feeling and behaving as the first steps in establishing a healthy lifestyle. As with the client, the family members need their own self-care plan, wherein they identify both the behaviors and thinking that need to stop, as well as the behaviors and thinking that support recovery. They must also learn the areas that are triggers for self-defeating thoughts and behaviors and develop a way in which to address them. Family treatment will facilitate learning healthy communication skills to assist in family members' ability to talk about the process as they engage in their newly learned ways of relating to the fact that the pain is real, but that the suffering is modifiable and optional.

Successful recovery practices for the client and family draw from many disciplines. Through mindfulness, cognitive practices and 12 Step philosophy, families and clients can develop skills to work around the "edges" of the pain (Kabat-Zinn, 2005). Instead of being absorbed in the search for a cure, families can learn that the solution lies with accepting the situation and the condition. Drawing from the gifts of addiction treatment, recognizing your powerlessness ultimately leads to genuine acceptance and improvement of health for the person in treatment and the family.

*Kevin gradually learned about pain recovery—the process of knowing that the pain exists, will always exist and will not kill him. Though they came from opposite directions, Kevin's parents ultimately came to a mutual understanding and acceptance of healthy boundaries. As a consequence of Bill's recovery work, he and Eleanor both took responsibility for their parts in coping with the pain, and now were better able to take responsibility for their roles in establishing a healthy, interdependent relationship with one another.*

By giving up the struggle, pain is lessened and suffering diminishes for the person in pain and his or her family.

## Parallels of the Impact of Chronic Pain and Addiction for the Family Members

Chronic Loss Condition
Adaptation of Rigid Family Roles
Extreme Relationship Styles—from Enmeshed to Disconnection
Chronic Caregiving Fueling Enabling
Distorted Boundaries
Preoccupation
Controlling Behavior
High Tolerance for Inappropriate Behavior
Social Isolation
Dysfunctional Family Rules (i.e., "Don't Talk; Don't Feel")

### References

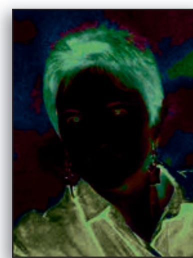

Bufalari, Ilaria et al. (2007). Empathy for Pain and Touch in the Human Somatosensory Cortex. *Cerebral Cortex*. 17: 2553–2561.

Flor, Herta et al. (2002). Conditioning: Learning that Pain Can Elicit Reward. Presented at Society for Neuroscience Annual Meeting, Orlando, Fla. November 2–7, 2002.

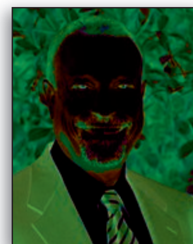
Griffin, M.R. (2009). "Is Chronic Pain on the Rise?" *Pain Management Health*.

Retrieved Dec. 2009 at http://www.webmd.com/pain-management/features/is-chronic-pain-on-the-rise.

Kabat-Zinn, J.(2005). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness.* Bantam Dell.


***Claudia Black, PhD** is Senior Clinical and Family Services Advisor for Las Vegas Recovery Center, and Senior Editorial Advisor for Central Recovery Press, publishing materials on addiction, recovery and behavioral health-care topics. For more information visit lasvegasrecovery.com, centralrecovery.com, or claudiablack.com.*


***Mel Pohl, MD, FASAM** is a Board Certified Family Practitioner and the Medical Director of Las Vegas Recovery Center. Has published numerous works on AIDS and addiction and chronic pain and addiction, including A Day without Pain and Pain Recovery: How to Find Balance and Reduce Suffering from Chronic Pain.*