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Pain Management Without Psychological Dependence: A Guide for Healthcare Providers

More than half of adults in the United States experienced chronic or recurrent pain in 2003 (Peter D. Hart Research Associates 2003). Effective management of pain not only reduces suffering, but also improves sleep, reduces affective stress, and increases levels of daily functioning (Roper Public Affairs & Media 2004; Schneider 2005). This publication will assist healthcare providers in understanding that opioid medications can effectively manage pain, distinguishing between physical and psychological dependence, and reducing their patients' risk of psychological dependence on opioids during pain management.

Nonopioid Pain Management

When patients present with chronic pain, providers should first offer patients one of several nonopioid pharmacological treatments. Acetaminophen and nonsteroidal anti-inflammatory medications can be used alone to treat mild to moderate pain or in combination with opioids to treat more severe pain (American Chronic Pain Association 2005; Hansen 2005; Jones et al. 2003; Strassels et al. 2005). Topical and injected anesthetics can also provide pain relief (Beers 2004–2005; Hainline 2005; Wisconsin Medical Society 2004). Adjuvant medication, such as antidepressants, anticonvulsants, steroids, anxiolytics, and muscle relaxants, can also be considered for pain relief (American Chronic Pain Association 2005; Beers 2004–2005; Hainline 2005; Hansen 2005; Wisconsin Medical Society 2004). Many medications with proven efficacy in pain management have also established potential for abuse and possible progression to psychological dependence. This potential for abuse requires some caution in their short- and long-term use that initially may increase a clinician's reluctance to appropriately use medication that might be required to alleviate pain.

Complementary nonpharmacological approaches should also be employed, especially

when longer term pain management is needed. Cognitive–behavioral techniques, such as relaxation training, biofeedback, stress management, and self-hypnosis (Beers 2004–2005; Hainline 2005; Jones et al. 2003) have been shown to increase pain thresholds, thus reducing the necessity for pharmacological treatments. Acupuncture, physical therapy, and neurostimulatory treatments can also effectively manage pain (Beers 2004–2005; Hainline 2005; Hansen 2005; Jones et al. 2003; Primm et al. 2004).

Pain Management With Opioid Medications

Providers can also prescribe opioids, such as fentanyl, hydrocodone, morphine, and oxycodone, alone or in combination with nonopioid treatments for pain relief. Opioids have been shown to effectively reduce cancer and acute pain, and most clinicians believe they also share a role in the management of chronic pain (Bloodworth 2005; Christo et al. 2004; Coluzzi and Mattia 2005). Healthcare providers may be reluctant to prescribe opioids to treat pain (Morley-Forster et al. 2003), especially for patients with substance use disorders (Cook et al. 2004). Reluctance may stem from inadequate training in pain management and/or addiction medicine, a lack of clinical practice guidelines that address pain management in patients with a substance use disorder, or fear of sanctions from regulatory agencies (Gourlay et al. 2005; Primm et al. 2004). Concerns about side effects, such as functional impairment and physical inactivity (Morley-Forster et al. 2003), and concerns about physical or psychological dependence (Cook et al. 2004; Morley-Forster et al. 2003) may also discourage providers from prescribing opioids to treat pain.

Physical Dependence, Psychological Dependence, and Pseudoaddiction

Although most people being treated for pain with opioids do not become psychologically dependent1 on opioids (Coluzzi and Pappagallo 2005; Lussier and Pappagallo 2004; Strassels et al. 2005), some may become physically dependent on the medication. Physical dependence is often a natural part of the long-term use of opioids prescribed for pain and can be managed effectively with appropriate identification and treatment (Coluzzi and Pappagallo 2005; Heit 2003; Strassels et al. 2005). Distinguishing between physical and psychological dependence on opioids is critical for the well-being of the patient. Physical dependence is a physiological adaptation to a substance, defined by a growing tolerance for its effects and/or withdrawal symptoms when use is reduced or ends (American Psychiatric Association 2000). Psychological dependence is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations (Heit 2003). It may occur with or without physical dependence and is conceptually characterized by impaired control over drug use, compulsive use, continued use despite harm, and craving for the psychic effects of the drug (American Academy of Pain Medicine et al. 2001; American Psychiatric Association 2000; Heit 2003; Strassels et al. 2005).

Determining a diagnosis of psychological dependence on opioids in the context of pain management requires careful evaluation; behaviors suggestive of psychological dependence may be due to pain that is undertreated. Commonly, this has been referred to as pseudoaddiction—problem drug behaviors that are due to undertreated

pain—and is often difficult to distinguish from psychological dependence on opioids (Alford et al. 2006; Christo et al. 2004; Coluzzi and Pappagallo 2005; Heit 2003; Savage 2002; Strassels et al. 2005; Weaver and Schnoll 2002). A patient who seems preoccupied with maintaining an adequate, continuous supply of medication or who spends a great deal of time trying to obtain additional medications may be seeking only pain relief (Alford et al. 2006; Christo et al. 2004; Heit 2003; Weaver and Schnoll 2002). Suspected inadequate pain management requires a comprehensive reassessment of the patient and changes to the treatment plan. When pain is adequately treated, pseudoaddictive behaviors should cease (Heit 2003).

Reducing the Risk of Psychological Dependence on Opioids

Psychological dependence not only can hinder the effective treatment of pain, but also can lead to increased pain and related health and social effects (Currie et al. 2003). The following are recommended to reduce the risk of opioid psychological dependence while providing effective pain management:

Obtain relevant patient background information (Cole 2002; Dews and Mekhail 2004; Savage 2002). Be aware of patients with a history of personal or familial problems with alcohol or drugs, legal problems, or misuse of prescription drugs; they have an increased chance of becoming psychologically dependent on opioids prescribed for pain (Michna et al. 2004; Savage 2002).

Use screening instruments to identify patients who are at risk or may be opioid dependent. Use the Opioid Risk Tool (Webster and Webster 2005), the Pain Medication Questionnaire (Adams et al. 2004), the Screener and Opioid Assessment for Patients with Pain (Butler et al. 2004), and the Screening Tool for Addiction Risk (Friedman et al. 2003) to identify patients in pain who are at risk for addiction.

Document appropriately. Have patients sign an agreement outlining the risks and benefits of the proposed treatment plan (Federation of State Medical Boards 2004; Gourlay et al. 2005), the objectives that will be used to determine treatment success (Federation of State Medical Boards 2004), the policy for medication refills and laboratory testing, and patient responsibility for opioid prescriptions (Bloodworth 2005; Cole 2002; Dews and Mekhail 2004; Hansen 2005; Passik and Kirsh 2005; Primm et al. 2004; Schnoll and Weaver 2003; Weaver and Schnoll 2002). Maintain comprehensive records of each visit, including medication dose, effectiveness of dose, and concerns about inappropriate use (Cole 2002; Dews and Mekhail 2004; Wisconsin Medical Society 2004).

Manage medications. Use the minimum dose necessary to provide adequate pain relief (Cole 2002; Hansen 2005; Primm et al. 2004; Schnoll and Weaver 2003; Weaver and Schnoll 2002). Instruct patients to use only one pharmacy to decrease the chance of medication abuse (Cole 2002; Primm et al. 2004; Schnoll and Weaver 2003).

Monitor patients closely for symptoms of physical and psychological dependence. Continually evaluate whether pain is being managed effectively and treatment goals are being met by observing and documenting the “four As”: analgesia, activities of daily living, adverse effects, and aberrant behaviors (Gourlay et al. 2005; Passik and Kirsh 2005; Primm et al 2004; Schneider 2005).

Possible Signs of Inappropriate Opioid Use by Patients

Patients taking opioids appropriately for pain management and those whose pain is inadequately relieved may occasionally display the behaviors listed below. However, the possibility of psychological dependence should be considered when a pattern of one or more of these behaviors is observed in patients.

Multiple episodes of “lost” or stolen prescriptions
Repeatedly running out of medication early
Aggressive complaints about the need for additional prescriptions
Drug hoarding during periods of reduced symptoms
Urgent calls or unscheduled visits
Injecting opioids intended for oral use
Using the medication to achieve euphoric effects
Unapproved use of prescribed opioid to self-medicate another problem, such as insomnia
Frequently missing appointments unless opioid renewal is expected
Unwillingness to try nonopioid treatments
Evidence of withdrawal symptoms visible at appointments
Concurrent alcohol or illicit drug abuse
Sedation, declining activity, sleep disturbances, or irritability unexplained by the pain or other co-occurring conditions
Deterioration of functioning at work, with family, or socially because of medication effects
Forging prescriptions or obtaining prescriptions from nonmedical or multiple medical sources
Selling prescription medicines
Sources: Breivik 2005; Coluzzi and Pappagallo 2005; Lussier and Pappagllo 2004; Primm et al. 2004; Savage 2002; Schneider 2005; Weaver and Schnoll 2002.

What To Do if Opioid Abuse or Dependence Is Suspected

People diagnosed with either substance abuse or dependence can be effectively treated for pain—even with opioids—provided their substance use disorder is addressed (Passik and Kirsh 2004). Healthcare providers who are treating patients for pain who are known to be or suspected of being psychologically dependent on opioids or other drugs should follow these guidelines to promote effective pain management treatment:

Immediately address the substance use problem (Passik and Kirsh 2004, 2005; Weaver and Schnoll 2002).
Increase monitoring. Initiate more frequent visits, and limit the amount of medication available at one time (Coluzzi and Pappagallo 2005; Jones et al. 2003; Lussier and Pappagallo 2004; Passik and Kirsh 2004; Savage 2002; Weaver and Schnoll 2002). Random urine drug tests detect the presence of illicit drugs or substances not prescribed for pain management and verify that the patient is taking the prescribed opioid instead of selling it (Coluzzi and Pappagallo 2005; Lussier and Pappagallo 2004; Passik and Kirsh 2004; Weaver and Schnoll 2002).
Include treatment for substance dependence in the pain management plan. Refer to a certified substance abuse treatment provider, initiate appropriate medication-

assisted treatment, and/or encourage participation in 12-Step programs (Compton and Athanasos 2003; Passik and Kirsh 2004; Savage 2002; Weaver and Schnoll 2002). With the patient's permission, consult and coordinate with the designated substance abuse treatment provider on an ongoing basis (Compton and Athanasos 2003; Jones et al. 2003; Lussier and Pappagallo 2004; Savage 2002; Weaver and Schnoll 2002).
Discontinue opioid treatment when warranted. Providing opioid analgesia to patients who are psychologically dependent does not necessarily worsen their dependence, nor will withholding opioids increase their likelihood of recovery (Alford et al. 2006; Compton and Athanasos 2003). However, unrelieved pain can trigger relapse (Alford et al. 2006; Compton and Athanasos 2003; Gourlay et al. 2005). Opioid therapy should be discontinued if more serious problems occur, such as prescription forgery, diversion of opioids, or continued inappropriate opioid use (Coluzzi and Pappagallo 2005; Lussier and Pappagallo 2004; Weaver and Schnoll 2002). If discontinuation is called for, the opioid dosage should be tapered to avoid withdrawal symptoms and other forms of nonopioid pain treatment should be offered (Weaver and Schnoll 2002).

How To Talk to Patients With Pain About Substance Use Problems

Be nonjudgmental—patients are more likely to be forthcoming.
Start with sweeping questions (e.g., "How helpful have your medications been for you?") rather than begin with questions about medication misuse.
Avoid yes/no questions that do not allow patients to express their feelings.
Ask questions about warning signs (e.g., "Have you ever taken your pain medication for other reasons?").
Listen to what patients says about how and why they take their medications.
Inquire about their willingness to try alternative, nonopioid forms of pain therapy.
Use existing tools such as the screening instruments discussed above.
Source: Passik and Kirsh 2005.

Resources

Definitions Related to the Use of Opioids for the Treatment of Pain provides uniform definitions of terms relating to substance use disorders in the context of opioid pain management that were agreed on by three national organizations, the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine (www.painmed.org/productpub/statements/pdfs/definition.pdf).
The Federation of State Medical Boards' Model Policy for the Use of Controlled Substances for the Treatment of Pain, produced in collaboration with pain experts across the country, provides guidance to State medical boards in developing pain policies and regulations (www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf).
The Federation of State Medical Boards' Model Policy Guidelines for Opioid Addiction Treatment in the Medical Office, developed under contract with the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment, provides a framework for developing rules and regulations overseeing the office-based treatment of opioid addiction (www.fsmb.org/pdf/2002_grpol_Opioid_Addiction_Treatment.pdf).
The American Medical Association's Pain Management: The Online Series offers 12

continuing medical education modules including “Assessing and Treating Pain in Patients with Substance Abuse Concerns” (www.ama-cmeonline.com).
The Wisconsin Medical Society’s Guidelines for the Assessment and Management of Chronic Pain provides guidelines on how to treat chronic pain using both opioid and nonopioid treatments (www.wisconsinmedicalsociety.org/uploads/wmj/pain_manageguides.pdf).
Each State has offices that provide information about licensed treatment programs (visit findtreatment.samhsa.gov/ufds/abusedirectors and www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3509/page4.asp).
SAMHSA’s Substance Abuse Treatment Facility Locator can also help identify treatment centers (www.findtreatment.samhsa.gov; 800-662-HELP).

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1. Many pain management articles and discussions use the term addiction to refer to psychological dependence. This publication uses the term psychological dependence to avoid any possible pejorative connotations of the term addiction.