Pain and Addiction

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Case

- 43 year-old female with a history chronic lower back pain presents to your clinic ongoing care. She has experienced pain difficulties since the age of 22, and now unemployed and receiving disability benefits. Psychiatrically, she has a history of depression, anxiety, and chronic insomnia. The patient is prescribed Vicodin, MS Contin, baclofen, Zoloft, gabapentin, Ativan, propranolol, atorvastatin, omeprazole, and Wellbutrin. Her pain is rated an 8/10, and she continues to report significant mental health difficulties.

Case (continued)

- The patient sees a psychiatrist every 3 months for "fifteen minutes."
- She reports that her psychiatric medications "do nothing."
- She continues to report high pain scores, and is requesting a medication change.
- There is no evidence of addictive behaviors. UDS and MAPS reports have been reassuring.

Chronic Pain – definitions

- Chronic pain is defined by the International Association for the Study of Pain as “pain that persists beyond normal tissue healing time, which is assumed to be three months.”
- All chronic pain disorders outside of cancer pain or pain at end of life are collectively labeled “chronic non-cancer pain”

Common Chronic Pain Conditions

- Fibromyalgia
- Osteoarthritis
- Headaches
- Chronic back pain
- Psychogenic pain syndromes ***

Psychogenic Pain Syndromes

- Physical/sexual abuse causing chronic pain
- This area is poorly studied, and quality literature with good treatment outcomes is lacking.
- Adults who have been sexually abused appear at disproportionately high risk of conditions such as
  - Irritable bowel syndrome
  - Non-epileptic seizures
  - Chronic fatigue syndrome
  - Chronic pelvic pain and other chronic pain syndromes
  - Fibromyalgia.

What is being offered as treatment?

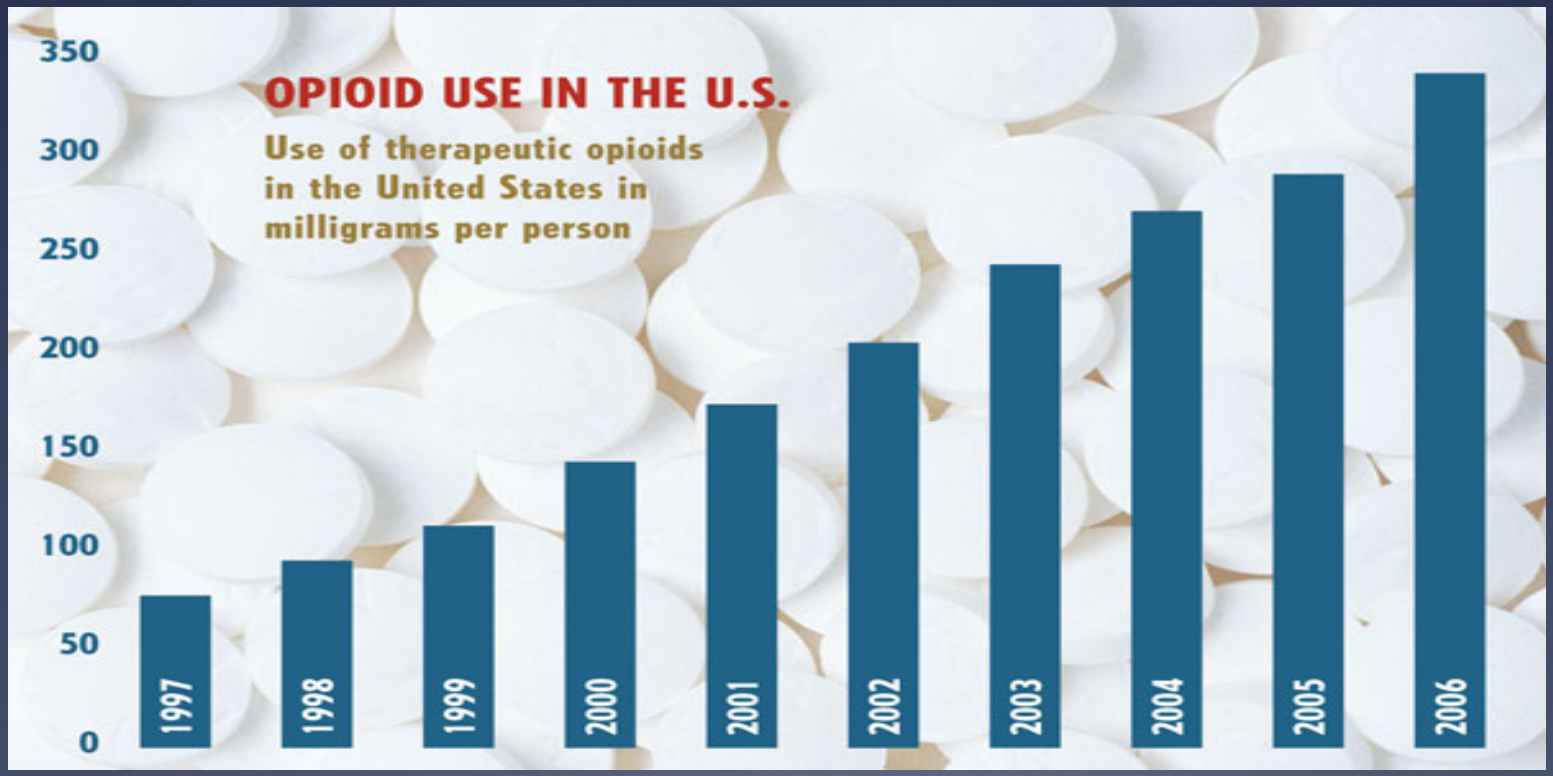
- **Even in cases of pain emanating from psychological causes, OPIATES are often utilized.**
- **Patient often continue to report disability and chronic pain, because the underlying etiology tis not being addressed.**
- **The use of opiates will produces a positive reinforcing effect, in some patients, which will mitigate underlying mood and anxiety difficulties.**

Opioids are DANGEROUS

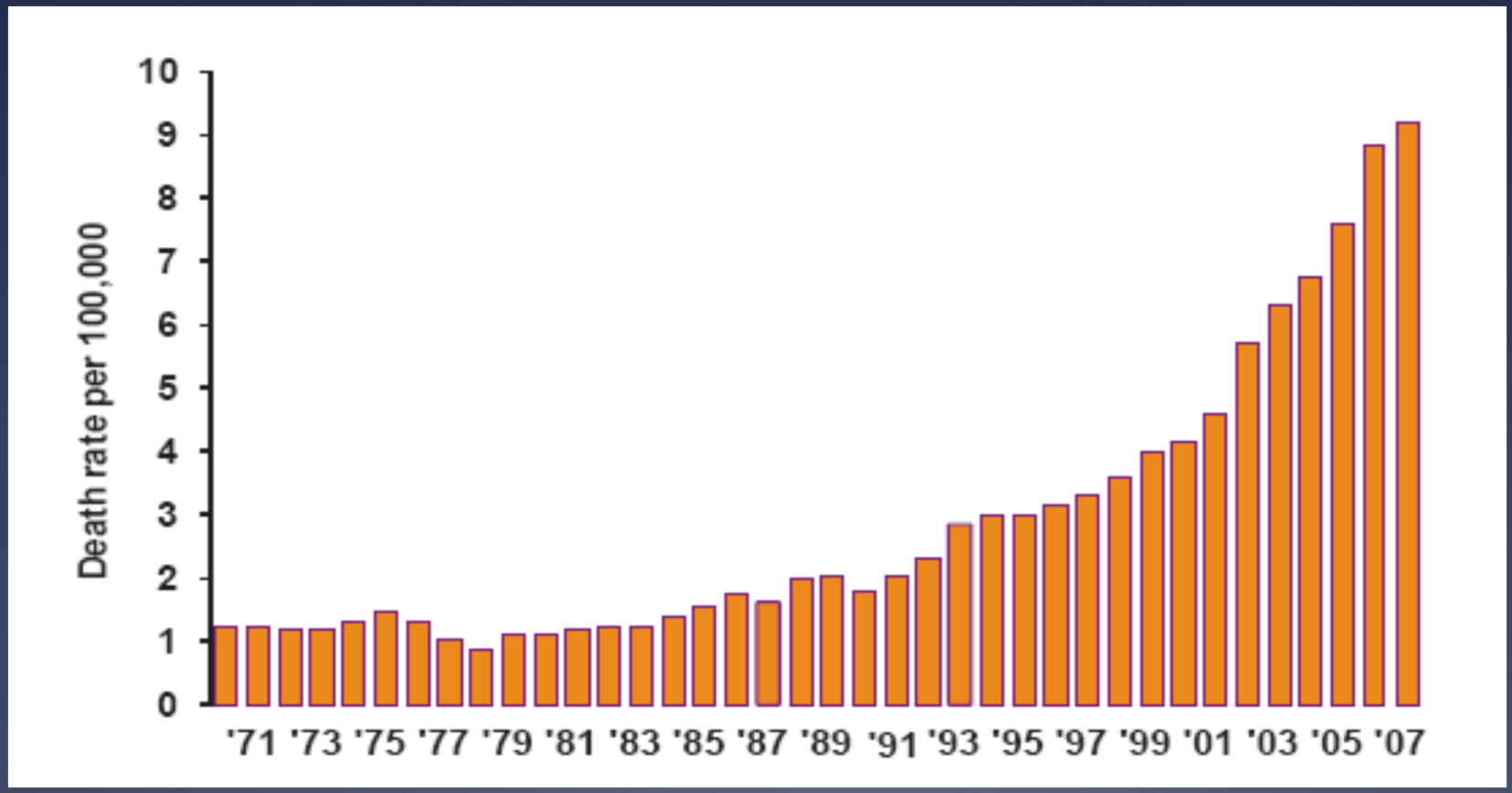
- **Overuse results in respiratory depression.**
- **Highly addictive nature of these drugs drives over-use, and may lead to overdose and death.**

Trends in Opiate Prescribing

* The use of therapeutic opioids-natural opiates and synthetic versions-increased 347% between 1997 and 2006, according to this U.S. DEA data.



Rate of Unintentional Drug Overdose Deaths in US 1970 - 2007



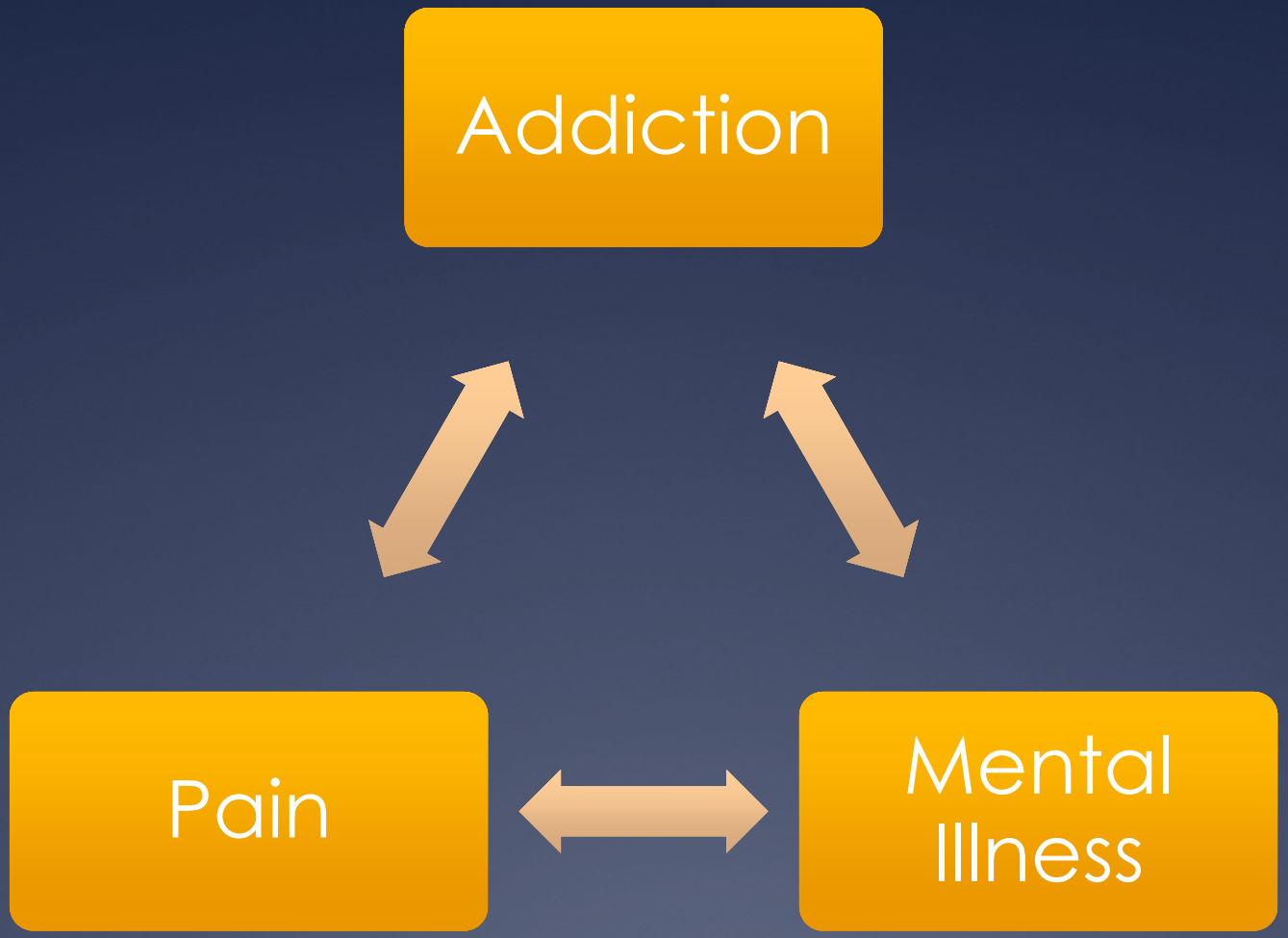
Why has this become such a problem?

We weren't prepared…

The Core Concept

- Clinicians need to be able to navigate through addiction-pain triangle, which is composed of three points:
  - Addiction
  - Pain
  - Psychiatric Illness

The Pain-Addiction Triangle



An Intro to Addiction

The first corner
of the triangle.

Addiction Definition

- A primary, chronic disease of brain reward, motivation, memory and related circuitry.
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Addiction Definition (cont'd)

- Addiction is characterized by:
  - Inability to consistently abstain from substance use
  - Impairment in behavioral control
  - Craving
  - Diminished recognition of significant problems with one's behaviors and interpersonal relationships.
  - A dysfunctional emotional response.
- Like other chronic diseases, addiction often involves cycles of relapse and remission.
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Addiction Definition

- The 4 "C's"
  - Loss of **C**ontrol
  - **C**ompulsive use
  - Use despite **C**onsequences
  - **C**ravings

What Drugs Can Cause Addiction?

- **Only certain drugs are addictive, and are able to stimulate the addiction circuitry.**
  - **Opiates/opioids**
  - **Cannabinoids (marijuana)**
  - **Psycho-stimulants (Adderall, cocaine)**
  - **Sedative/hypnotics (Benzodiazepines)**
  - **Nicotine**
  - **Alcohol**
- **Relative very few chemical compounds can stimulate the addiction circuitry, in comparison to all pharmacologically active substances.**

Opiates: More than Analgesia

- **In the VULNERABLE population, opiates may induce:**
  - **A euphoric effect**
  - **An immediate anti-depressant or anxiolytic effect (can be strongly reinforcing in the depressed or anxious patient).**
- **This can result in the patient developing a strong EMOTIONAL ATTACHMENT to the drug, which can occur in the absence of addiction.**

Different Phenotypes of Drug "Dependence"

- **True drug addiction**
- **Strong emotional attachment, without addiction**
  - **Presentation very similar to addiction.**
  - **Strongly correlated with co-occurring psychiatric illness.**
  - **Patients will not agree to tapering or discontinuation, but NOT due to addiction related psychological drives.**

Pain or Addiction?

The million dollar question…

Pain or Addiction ?

- It can be BOTH.
  - This may not be a question of one or the other. Both ailments may be present.
- Patients may embellish pain reporting as means to attain opiates and other controlled substances.
- Be empathetic, nonjudgmental, professional, and thorough in your assessment.

Subtle cues

- Look for the following:
  - Posture
  - Facial grimacing
  - How patient ambulates in and out of clinic.
  - Ask MA's/RN's to observe patient in waiting area and how they act during vital checks and the initial office check-in.
  - Consider keeping the door to exam room open or slightly ajar to facilitate observation of the patient before you walk in.

Is it Pain or Addiction?

- **Behavior driven by the disease of addiction may be manifested by:**
  - **Exaggerated pain scores which do not correlate to physical exam findings.**
  - **Reported lack of benefit on high dosage regimen (ex. 10/10 pain while on 300mg of MS Contin)**
  - **Patients becoming argumentative, angered, or threaten legal action if demands are not met.**
  - **Patient's making the provider feel incompetent or inadequate ("Whenever Ms. Smith comes in, I always feel uncomfortable, and she makes me feel bad.")**

Mental Health

Be careful with that prescription pad…

Treating Psychiatric Disorders

- **Do not jump to conclusion regarding diagnoses.**
  - **Patients are very complex, with likely underlying unconscious conflicts and a history of traumatic experiences (emotional, sexual, physical).**
- **Avoid temptation to prescribe**
  - **Patients with drug addiction will very persistent regarding drug therapy to help with emotional distress.**
  - **The use of SSRI's and other antidepressants may be helpful, but be confident in what you're treating.**
- **Take time to know the patient**

Psychiatric Illness with Chronic Pain

- **Depression and other mood disorders.**
- **PTSD**
- **Personality Disorders**
- **Somatic Symptom Disorders (ex. Hypochondriasis and conversion disorder)**
- **Anxiety disorders.**
- **"ADHD," which contributes to controlled substance polypharmacy with stimulant Rx.**

What TO do in the Psychiatric Patient with Chronic Pain

- **Vigorously screen for mental health difficulties, especially mood disorders and PTSD.**
- **Delicately identify past traumatic experiences, which may be contributing to the patient's presentation.**
- **Refer to psychotherapy, when necessary. Ideally to a therapist who has experience in working with chronic pain patients.**
- **Be CAUTIOUS with prescription medications, and do not contribute to a polypharmacy picture.**

What NOT to do in the Psychiatric Patient with Chronic Pain

- **DO NOT PRESCRIBE BENZODIAZEPINES**
  - **Absolutely no evidence supports this practice.**
- **Avoid the use of psychostimulants, including Adderall and methylphenidate, in patients with a history of addiction, unless there is unequivocal evidence of ADHD.**
- **Do not treat all emotional complaints with a prescription.**
  - **These will be emotionally uncomfortable but pharmaceutical intervention is not always the right intervention.**

Let's Summarize

Putting it all together

So What's Going On?

- Refractory pain syndrome that has not responded to conventional treatments.
- Patient is disabled, and continues to request or demand opiate analgesics.
- Behavior is driven by:
  - Addiction alone.
  - Addiction + chronic pain
  - Psychogenic pain syndrome (pain due to underlying emotional trauma)
  - Somatic Symptom Disorder
  - Any combination of the above

Prioritization of Clinical Concerns

- Addiction should be address first
  - Very difficult to treat chronic pain or delineate a mental health concern with active drug addiction.
- Pain Management
  - Pharmacotherapy – avoid opioids, is possible.
  - Psychosocial interventions
    - CBT
    - Biofeedback
    - Mindfulness therapies
- Mental Health
  - Pharmacotherapy – be very judicious.
  - Psychotherapy

Pharmacotherapy Considerations in Psychiatric Patients

- Avoid benzodiazepines, and other sedative/hypnotics.
  - Have not shown to be beneficial in the chronic pain patient.
  - Dangerous synergy with opiates.
  - Tend to lead functional decline.
- The use of stimulants is not recommended.
  - Anecdotal evidence.
- Address issues of poly-pharmacy, and discontinue what is likely not necessary.

Thank you!

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