Transitioning from Pain Initiation into Addiction Treatment
"They Just Want to Feel Normal"

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Conflict of Interest Disclosure

Authors’ conflicts of interest:
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Educational Objectives

Session Goal:
Describe the transition of adults who are using opioids for pain through their entry into medication-assisted treatment for opioid use disorder.

At the conclusion of this session learners should be able to:

• Recognize commonly used definitions of opioid use, misuse, and addiction.
• Understand how participant interviews are used to develop a grounded theory of transition into opioid addiction.
• Explore how clinical care can be improved to reduce risks of opioid addiction for people with pain.
A case study

• Acute injury
• New prescription opioids
• Antidepressant suggested
• Moved to Florida to receive dose

One year later

• Weight gain
• Irritable
• Strained relationships
• Focused on opioids
  • >300mg Morphine/day

Standard ED care

Stigma

Judgement

Anger/Shame
Related scientific contributions

Remaining problems:

Increased X 3 since 2010

Trends in National Overdose Deaths

Number of Deaths Involving Prescription Opioid Pain Relievers

Number of Deaths Involving Heroin

Source: National Center for Health Statistics, CDC Wonder
Medication-assisted treatment (MAT) for opioid use disorder

The highest rise in opioid overdose deaths involved heroin - 6.2-fold increase from 2002 to 2015.
60-80% of those on methadone for treatment of opioid use disorder have persistent pain.
Pain is frequently managed inadequately or inappropriately among MAT populations.
Pain significantly impacts quality of life and can negatively affect addiction treatment. (Eyler, 2013)

Poor access to specialized pain care or skills training: “My doctor kicked me to the curb.”

Primary randomized controlled trial

Majority of participants (n=44; 73%) reported that their first use of opioids was in response to a painful event.

Definitions

Physical dependence: physical condition caused by chronic use of a tolerance forming drug - drug withdrawal causes unpleasant physical symptoms.

Misuse: Incorrect use of a medication by patients, using drug for a purpose other than that for which it was prescribed (too little or too much, take in ways not intended by the prescriber).

Addiction: primary, chronic disease of brain reward, motivation, memory, and related circuitry. Characterized by inability to abstain or control use, craving, and dysfunctional emotional response.
Understanding Opioid Misuse

“Misuse” of opioids = taken other than prescribed

11.5 million in U.S. misused prescription pain relievers in 2016

Gaps in care for opioid addiction treatment population

The presence of pain significantly impacts quality of life and can negatively affect addiction treatment. (Eyler, 2013)

- Treatment complicated by:
  - heightened sensitivity to pain (hyperalgesia)
  - high opioid tolerance
  - cross-tolerance to pain medicines
  - illicit substance use
  - may need to stabilize addiction before pain can be addressed.

  “Treat the addiction, not the pain.”

Gaps in understanding how people transition from appropriate opioid use for pain to addiction treatment

Unknown true incidence - estimated 21-29% “misuse” and 8-12% “addicted”

- Increased risk of OUD with increased opioid dose
- Past teachings: Those with pain cannot become addicted
- Risk factors include genetics, psychiatric disorders, younger age, social/family environments
DSM-5 Criteria for Opioid Use Disorder (OUD)

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount of an opioid.
11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome. b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (Copyright 2013). American Psychiatric Association. Note: This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Purpose:

The purpose of this grounded theory research study was to identify predominant categories involved with the process of initially taking opioid medications through enrollment in an outpatient medication-assisted opioid treatment program for adults with opioid use disorder and a chronic pain diagnosis.
Methods

Design:
• This study used a grounded theory qualitative approach.
• Approach was chosen because it has the ability to provide in-depth detail from participants’ perspectives of living with persistent pain, taking opioid medicines, and the eventual need to enter into a treatment program for opioid addiction.
• The end result is the development of theory. (Corbin & Strauss, 2015)

Participants:
• Inclusion criteria: adults who were currently enrolled in medication-assisted treatment and reported the reason they initiated opioid use was for pain (recruited from RCT).
• 10 adults who were enrolled in a single outpatient methadone clinic in the Pacific Northwest.
• 10 initial interviews & 3 follow up interviews = 13 total interviews

Results
• The study resulted in the development of a new theory titled: “Living with Persistent Pain: From Opioid Initiation to Substance Use Treatment.”
• The theory includes three predominant categories that were supported from the participant data (transcripts):
  • Addiction pathway
  • Becoming normal
  • Relationship spectrum
Core Category: Living with Pain

Overarching theme most consistently identified in the data and relatable to every category

- “But there’s no trapdoor. There’s no out from it [pain]. There’s things that help, but it’s always there… I start thinking about that fact, unless something changes, this is going to be here for the rest of my life… that’s when I start getting depressed and feel hopeless.”

- “…it creates a lot of underlying stress when you have that pain all the time and there’s no escape from it…. it starts to make you feel almost claustrophobic.”

Category: Relationship Spectrum

- “… it was also a lot easier for my boyfriend to control me, I think, that way also with the pain pills. He knew that – that was a big way to control me in the ways that he wanted to. I didn’t see that until I got out of the relationship… So at first it seemed like he was supporting me and loving me and everything, but after a time, I saw that it wasn’t really support or love.”

- “There was a reason they [providers] didn’t let me die… My cardiologist came in and saw me and he told me… ‘You’re going to go to the Methadone Clinic.’ Oh, I am? ‘I’m not asking you. You’re going… we can’t have this. I’m not going to have you die, not after everything we’ve been through. We’re not doing that, so you’re going to the Methadone Clinic.’”
**Category: Relationship Spectrum**

- “I hear [from my family] ... 'When are you finally going to get off of that stuff?' And I tell 'em, you know, I might not ever be able to get off that stuff [methadone], so – you know, they don’t understand the ‘maintenance’ part of the methadone.”
- “The first thing he [my doctor] told me was, ‘Don’t expect to get anything from me,” pretty much. Which is wrong, I mean, that’s totally wrong. I can’t get past that to – to address all of my pain issues.”

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**Category: Addiction Pathway**

- Described as the process that eventually resulted in opioid misuse and addiction.
- What most often began as a prescription for a medical issue, commonly turned into participants misusing opioids by increasing the amount and frequency of medications that they used.
- This category includes 3 supporting concepts:
  - Opioid initiation
  - Craving
  - Transition into dependency

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**Category: Addiction Pathway | Concept: Opioid Initiation**

- “I was actually just about to turn eighteen years old and I was in a car accident. I got set up with a doctor and he started giving me, ah, pain pills for it... I think it was like a year-and-a-half later I was still on those pain pills. I wasn’t really given any other options than...chronic pain pills and opioids for it.”
- “I gave birth to my 4th pregnancy, and my sacrum was fractured and it never healed... It was interrupting my day and night - my life in all facets... I was given opioids for the pain.”
**Category: Addiction Pathway | Concept: Craving**

- “…and it was just like this loud thought of just go get the pain pills. It will fix this. Because it was such a, um, debilitating thing and such an unwanted feeling.”

- “It was just like…one of the hamster wheels…it seemed to never stop - getting off the hamster wheel and thinking, my brain would tell me, you know, this pain can stop if you just go get pain pills.”

**Category: Addiction Pathway | Concept: Transition into Dependency**

- “When it comes to opioids, you don’t realize you’re addicted until you try to quit. You know that when you’re trying to quit or not take ’em and you get sick….it’s like having the flu cause your whole body aches….a miserable feeling.”

- “What happens is we get to the point that we are willing to give everything we have to it, and we do. We give to it. We keep giving until we have given all we have to give.”

**Category: Becoming Normal | Concepts: Turning Point/ Seeking Help**

- “So one day I just said ‘Enough’s enough. I don’t want to do this anymore.”

- “…I decided to do something proactive and make a change. And I went out – the very next day after I got out of the hospital after that incident, I went to the methadone clinic.”
"I would say ninety percent of the people that come to these [Medication Assisted Treatment] clinics… they just want to feel normal."

"… eventually you got to a point where it was what it (methadone) should do- just take away the withdrawal symptoms and the cravings and allow you to wake up in the morning without having those awful cravings and thoughts… it really does help you to feel just normal and I guess normal being not in pain, um, aware and alert."

"Not all days are rosy, but there’s days I’m happy – where I’m happy in this journey of my life."

**Implications for Nurses & other Healthcare Providers**

1. Discuss non-opioid and non-pharmacological options for pain early on.
2. Establish collaborative relationships with patients = shared decision making in developing realistic pain management goals.
3. Educate patients about potential pitfalls and realistic benefits of using opioid medications before initiation and often throughout course of treatment – assess for substance use risk.
4. Begin to discuss tapering plan early on and support patients throughout.
5. Ensure that MAT populations with chronic pain receive coping skills training that addresses their capability to deal with stress and distressing symptoms.
6. Discuss treatment options (MAT, Counseling) and desire for becoming normal.
7. Offer hope – supportive healthcare relationships encourage, support, and accept.

**Summary**

"Living with pain" was a complex and tumultuous process from the original painful experience, to initial use of opioids, to ongoing recovery in MAT.

Relationships that either support or detract from recovery are critical to decision points and quality of life.

Decision to enter medication-assisted treatment was key to "becoming normal."

Continued need to develop and test more options to assist in managing pain within context of medication-assisted treatment.

Physical and emotional pain should be addressed with compassion in all phases of treatment.

Trusting relationships that provide nonjudgmental support and advocacy are essential for people with pain and comorbid substance use.

References


