

# Pseudoaddiction versus Addiction in a Pain Population

by

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### Abstract

While addiction is a disease that most in the healthcare profession are aware of, the same does not hold true for pseudoaddiction, a phenomenon which is commonly misconstrued as a form of drug-seeking behavior with the primary aim of abuse. Many clinicians refuse to treat pain patients complaining of inadequate pain relief, for fear of addiction. Some substance abuse counselors misdiagnose their clients as addicts. Current research in this area describes the lack of understanding related to this drug-seeking behavior and the negative outcomes for the patient/client as a consequence of both past and current misconceptions on the issue. Further empirical research and healthcare professional education on the differences between addiction and pseudoaddiction are needed in an effort to elucidate this phenomenon.

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## Pseudoaddiction versus Addiction in a Pain Population

### Introduction

According to Corey, Corey, and Callanan (2003), “ethics pertains to the beliefs we hold about what constitutes right conduct” (p. 11). If an individual presents to a physician complaining of severe pain, is it not the physicians' ethical obligation to make sound clinical attempts to alleviate the pain? If the physician fears that the patient may become addicted to the pain medication, should he withhold effective treatment or investigate further to rule out the possibility of pseudoaddiction due to the under-treatment of his patient's pain? If he lacks awareness and education of this phenomenon, is he not performing a disservice to his patient?

While research performed on drug addiction is extensive, studies performed to-date on pseudoaddiction are limited and seemingly qualitative in nature. According to Leedy and Ormond (2005), “When little research exists on a topic...a qualitative study can help define what is important -- that is, what needs to be studied” (p. 134). Qualitative studies encompassing pseudoaddiction have indicated the need to further research this phenomenon. Current research suggests that the misconceptions surrounding pseudoaddiction are numerous. Chronic pain patients, whose complaints of pain are not adequately addressed, may display aberrant, drug-seeking behaviors that are mistaken for addiction. Schnoll and Weaver (2003) contend, “Pain is often undertreated, which may lead to drug-seeking behaviors.” (p. 534). According to the U.S. National Institute of Health, National Cancer Institute (2004), “The term pseudoaddiction was coined to depict the distress and drug-seeking that can occur in the context of unrelieved pain. The cardinal feature of this syndrome is that the aberrant behaviors disappear when an effective analgesic intervention is administered” (Undertreatment section, ¶ 1).

### Background/Statement of the Problem

Missionary surgeon and Nobel Peace Prize recipient, Albert Schweitzer once stated, "Pain is a more terrible lord of mankind than even death itself" (Melzack, 1990, ¶ 1). Chronic pain destroys an individual's quality of life. In its most severe state it can lead a patient to suicide. The physical attributes of pain are similarly intense. Severe, chronic pain impairs not only sleep but also appetite, thus creating fatigue and reducing the accessibility of vital nutrients to body organs. It can delay recovery from injury or illness and, in compromised patients, may determine the difference between life and death (Melzack). Many patients with chronic pain also experience severe depression as a reactive symptom to the under treatment of their pain (Grinstead, 2004). Some research suggests that pain is one of the primary indicators of depression. In addition, high levels of pain-associated physical impairment were correlated to high levels of depression (Gallagher, 2004). This comorbidity makes the process of healing the whole of the patient even more challenging.

Bemis (2003) argues that pain activates stress responses throughout the body. These responses are the body's effort to protect itself from further harm. Table 1 illustrates some of the physiological and psychological stressors manifested by the presence of pain.

Table 1

Physiological/Psychological Stressors Manifested  
in the Presence of Pain

Affected Area	Reaction
Cardiovascular	Escalated blood pressure, rapid heart rate, increased cardiac output, peripheral, systemic, and coronary vascular resistance, myocardial oxygen expenditure, coagulation, deep vein thrombosis
Cognitive	Diminished cognitive performance, confusion, distorted disposition, high somatization, and anxiety
Endocrine	Increased antidiuretic hormone, epinephrine, norepinephrine, aldosterone, glucagons, with decreased insulin and testosterone
Gastrointestinal	Reduced gastric and intestinal motility
Genitourinary	Urinary retention, fluid burden, depression of immune responses
Quality of Life	Anxiety, trepidation, despondency, insomnia, suicide ideation
Metabolic	Hyperglycemia, glucose intolerance, insulin resistance, protein catabolism
Muscular	Impaired muscle performance and immobility with resulting muscle spasms
Pulmonary	Suppressed volume and flow, along sputum retention resulting in infection and atelectasis

Note. From "Contemporary pain management," by A.P. Bemis, 2003. Harmful Effects of Pain Section. Retrieved January 12, 2006, from [http://www.nursingceu.com/courses/13/index\\_nceu.html](http://www.nursingceu.com/courses/13/index_nceu.html)

In 1995, the Journal of the American Medical Association reported that at some of our nation's most prestigious medical centers more than 50% of cancer patients passed away in serious, uncontrolled pain. One reason cited was the fact that some physicians are hesitant to prescribe appropriate medications for fear of addicting their patients (Herper, 2004).

A survey study involving 386 Texas physicians was conducted in order to ascertain their knowledge related to pain management along with their general attitudes concerning chronic pain patients. The results of this 59-item survey indicated that a considerable number of participating physicians suffered from opiophobia (a bias against using opioid medications), along with a lack of knowledge about appropriate pain management practices. In addition, the responding physicians admitted to holding negative views about patients with chronic pain (Winstein, et al., 2000, Results section).

If the professional mandate of the health care professional is the obligation to relieve suffering, then the clinicians are breaching their obligations by accepting antiquated myths about the use of opioids in the face of evidence to the contrary (Furrow, 2001). According to Stegman (2001), "outdated fears of addiction to opioids remain a barrier to effective pain control..." (p. 31). The concerns surrounding addiction have hindered efforts to properly address inadequate pain treatment. As a healthcare professional, it is incumbent upon us to make the ethical decision as to whether it is appropriate to require blameless patients to suffer in pain due to our own ignorance and/or hesitancy in meeting their quest for pain relief.

The over-arching apprehension with drug addiction has served to thwart efforts focused on inadequate pain management practices. As a result, some chronic pain patients have been forced to revert to illegal means to obtain pain relief, risking not only legal ramifications, and the likelihood of being labeled as a drug addict, but forcing them to endure agonizing suffering. It is

imperative that those healthcare professionals directly or indirectly exposed to chronic pain patients displaying aberrant, drug-seeking behaviors understand the core differences between true drug addiction and pseudoaddiction.

### Research Hypotheses

This writer would propose the following hypotheses in support of her integrative project:

1. The majority of chronic pain patients displaying drug-seeking behaviors are a direct consequence of inadequate pain management, not an addictive disorder.
2. Aberrant, drug-seeking behavior displayed by chronic pain patients will be eliminated with adequate pain management.

### Project Rationale

The primary goal of this integrative project is to examine the requirements of healthcare professional education surrounding the necessity to recognize and accept that there are core differences between true drug addiction and pseudoaddiction as the treatment strategies and/or interventions would differ greatly in these two distinct populations.

Individuals in chronic pain will take desperate measures to find relief. The primary distinction between the patient in pain and the drug addict is that once the patients' pain is relieved, they will discontinue their drug-seeking behaviors, while the drug addict will continue in their quest for a narcotic analgesic euphoria (The National Foundation for the Treatment of Pain, 1999). The majority of patients complaining of pain are not seeking a drug-induced euphoria, but rather relief from their unbearable discomfort (Gerhardt, 2004).

While current research indicates that patients with unrelieved chronic pain will exhibit a high percentage of drug-seeking behaviors (Kowal, 1999), the investigations also describe the lack of understanding related to this drug-seeking behavior and the negative outcomes for the

patient/client as a consequence of both past and current misconceptions on the issue. Further empirical research and healthcare professional education on the differences between drug addiction and pseudoaddiction are needed in an effort to elucidate this phenomenon (Passik, et. al., 2000).

### Definition of Terms

Table 2 identifies terms and definitions relevant to this paper that may not be familiar to the reader.

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Table 2

Definitions of Terms

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Addiction	A primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations; addiction is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.
Opioid	A class of drugs (e.g., heroin, codeine, methadone) that are derived from the opium poppy plant, contain opium, or are produced synthetically and have opium-like effects. Used to relieve pain.
Pain	Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage
Pseudoaddiction	Patient behaviors that may occur when pain is undertreated (e.g., increased focus on obtaining medications or “drug seeking,” “clock watching,” use of illicit drugs, or deception) and that can be mistaken for true addiction.

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Note. From American Pain Society (2006). Retrieved January 12, 2006, from <http://www.ampainsoc.org> and Savage, et al. (2001). Definitions related to the use of opioids for the treatment of pain – A consensus document.

### Literature Review

Leedy and Ormrod (2005) opine that case studies help the researcher to draw conclusions regarding the extent by which findings can be generalized to a larger, target population. The following case study reports are presented as evidence for the lack of understanding on the part of healthcare professionals and their knowledge of the core differences between true drug addiction and pseudoaddiction.

#### *Case Study #1*

A 34-year old ileostomy patient presented in the surgical intensive care unit complaining of uncontrollable abdominal and rectal pain. The patient was infused with morphine (opioid), but continued to complain of pain and subsequently demanded the pain medication, meperidine (synthetic opioid) stating that it had been effective analgesic with his Crohn's disease. The attending physician informed both the patient and his family that because of the patient's apparent "addiction", he was taking him off all opioids. The physician was not familiar with the phenomenon of pseudoaddiction. The patient's family demanded a palliative care consult. Results indicated that the patient's escalating pain was due to a combination of opioid withdrawal and postoperative pain. Opioid medication was reintroduced and the patient's drug-seeking behaviors abated without event (Porter-Williamson, Heffernan, & von Gunten, 2003).

#### *Case Study #2*

Weissman and Haddox (1989) presented a case report of a 17 year-old leukemia patient with a negative history for drug or alcohol abuse who presented in the hospital with high fever and complains of chest wall pain. He was infused with morphine, but continued to complain of unrelenting pain. The staff eventually consulted with the cancer pain management team in how

to address the patient's opioid "addiction." The pain management team reviewed the patient's chart and ordered additional opioids. Within 24 hours the patient's pain resolved without event. The team surmised that the under treatment of pain forced behavioral changes (pseudoaddiction) similar to those displayed in an addicted individual, yet the behaviors in this case, were based solely on inadequate pain management (Weissman & Haddox, 1989).

#### *Case Study #3*

A substance abuse counselor reported alleged drug-seeking behaviors in one of her clients (57 year-old male with chronic low back pain). Based on the counselor's findings, his primary care physician made the clinical decision to taper the patient from his opioid, despite the patient's protests. During the process of titrating the patient from opioids, he committed suicide. In the course of the litigation process it was determined that the substance abuse counselor was practicing outside of their expertise as he had no training in pain medicine or addiction. In addition, the physician was charged with treatment below the standards of good medical care as expert witnesses could not rule out the possibility of pseudoaddiction (Fishbain, 2002).

#### *Case Study #4*

An elderly male diagnosed with prostate cancer that had metastasized to the bone and with a prognosis of six months to live was admitted to a nursing home. His physician wrote orders for oral morphine (opioid) to effectively address the patient's pain needs. These orders were countermanded by a nurse who assessed the patient as being "addicted." A court trial ensued where, as a consequence of the nurse's unfounded assessment, the patient "experienced physical pain and suffering and mental anguish, described as inhuman treatment inflicted without regard to the consequences and without care as to whether or not the patient received analgesic

relief and without care that the result and procedures were torture of the human flesh" (Furrow, 2001, p. 42).

According to Leedy and Ormond (2004), "Survey research involves acquiring information about one or more groups of people...the ultimate goal is to learn about a large population by surveying a sample of that population" (p. 183).

#### *Survey Study #1*

Passik, et al. (2000) conducted a survey study with 52 oncology patients from inpatient units at Memorial Sloan-Kettering Cancer Center, and 111 female HIV/AIDS patients participating in a larger AIDS study. The primary research question being evaluated in this survey study was an attempt to assess aberrant drug-seeking attitudes and behaviors in those patients with pain severe enough to require opioid medications. The instrument utilized in the study was a pilot questionnaire evaluating present medication use, drug history, and study participants attitudes regarding aberrant drug-taking behaviors. Results of the survey study indicated that though none of the study participants had a previous history of drug-seeking behavior, chronic pain patients would consider engaging in aberrant drug-seeking behaviors if their pain were untreated.

#### *Survey Study #2*

Cowan, Allen, Libretto and Griffiths (2001) undertook a survey study in 39 street drug users and 36 chronic non-cancer pain patients in an attempt to ascertain any differences in drug-seeking behaviors between the two cohorts. Street users were defined as those individuals who engaged in drugs use for the sole purpose of "getting high". Results clearly demonstrated that the chronic non-cancer pain patients, who had achieved adequate pain relief, did not engage in drug-seeking behaviors, nor were they seeking a "high." Conversely, the street drug users

displayed continued drug craving and compulsive drug use despite negative consequences, and readily admitted to taking illegal opioids to escape reality.

### Proposed Methodology

This writer suggests that results generated from a quantitative study might serve to convince health care professional working directly or indirectly with chronic pain patients/clients that a patients/clients drug-seeking behaviors could be an indication of inadequate pain management, not addiction. The healthcare professional should be charged with the ability to understand the difference between the two behaviors and act accordingly.

Leedy and Ormrod, (2005) contend, “Quantitative research is used to answer questions about relationships among measured variables with the purpose of explaining, predicting, and controlling phenomena” (p. 94). Some professionals argue that quantitative research is more valid in its ability to draw objective conclusions. These types of studies represent the mainstream approach to empirical research.

The proposed study protocol would encompass an experimental research-designed pilot study with both an inpatient and outpatient phase in 15 chronic pain cancer patients diagnosed with stable disease. The study participants would be recruited from a pain management clinic where they are currently receiving a single entity, immediate release opioid medication and displaying aberrant drug-seeking behavior. Institutional Review Board (IRB) approval and subject informed consent would be obtained prior to study entry.

Independent variable: Single entity, immediate-release opioid medication prescribed for chronic cancer-related pain

Dependent variables: (a) Quantitative and qualitative toxicology serum blood profiles for opioid medication at peak level (1-hour post dosing), (b) Pain assessment scales obtained (numeric and/or pictorial) as displayed in Appendices A and B.

Inpatient phase: Baseline pain assessment would be performed utilizing pain assessment scales. A baseline blood draw would be performed to establish quantitative and qualitative levels of the single entity opioid. Subsequent increases in dose of opioid titrated to pain relief as evidenced by repeated pain assessment scales. Once pain relief is achieved, blood would be drawn 1- hour post-dosing.

Outpatient phase: Serum blood profile and pain assessment would be obtained at monthly clinic visits at the same time interval (1-hour post-dosing).

Quantitative statistical analyses would be performed on results from pain assessment instruments, and serum blood level results.

Opioid blood level should remain approximately the same as the last inpatient blood level. An increase would suggest non-prescribed use of opioids. The presence of illicit drugs and/or other narcotic analgesics would also suggest the non-prescribed use of opioids. These scenarios would be examined further by a multi-disciplined healthcare professional team for possible drug abuse/addiction. Those study participants who previously presented with aberrant drug-seeking behavior and whose alleged untreated pain was relieved with increased doses during the inpatient phase of the study, yet continue to present with increased blood levels, should be monitored for possible drug addiction intervention. Those study participants who previously presented with aberrant drug-seeking behavior and whose untreated pain was relieved with increased doses during the inpatient phase, and who present with continued steady blood levels, would fit the definition of pseudoaddiction.

## Results

The case reports outlined in the literature review section of this paper illustrate the features of pseudoaddiction, which in the opinion of Weissman and Haddox (1989) typically involves three phases:

1. Onset of pain followed by administration of opioid medications at suboptimal doses. The patient subsequently requests additional analgesics for pain relief.
2. The patient comes to the realization that in order to obtain additional medications, he/she must convince the healthcare professional that their pain is real and severe enough to warrant additional analgesics. The patient may then engage in exaggerated behaviors (crying, moaning) and become less cooperative with the staff, which begins to suspect that the patient has an addiction problem.
3. As the patients' pain remains unresolved, he/she may begin to engage in increasingly bizarre drug-seeking behavior in an attempt to convince the staff for the need of additional pain medication. In response, the patient is labeled as an "addict" and the staff will seek to avoid additional conflict by avoiding the patient.

*Figure 1.* Phases of pseudoaddiction.




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From "Opioid pseudoaddiction – an iatrogenic syndrome," by D.E. Weissman and J.D. Haddox, 1989. *Pain*, 36(3), p. 365.

At the juncture of phase three, the patient might be referred to a mental health professional for the treatment of his/her "addiction". At this point, any chance of providing sufficient analgesia will have vanished for fear of fueling the addiction and the patient is left to suffer in a crisis situation. Once a patient is labeled as an addict, most physicians will be reluctant to provide any analgesia for fear of contributing to the patients' addiction problem, regardless of any extenuating circumstances (Porter-Williamson, et al., 2003).

Triangulation from case studies would be required in an attempt to generalize results and draw valid, replicable findings, but the case studies help illustrate the basic need of healthcare professionals working with chronic pain patients displaying aberrant, drug-seeking behaviors to further investigate the cause of their uncharacteristic conduct.

The results of the survey studies outlined in the literature review section of this paper inferred that chronic pain patients would consider engaging in drug-seeking behaviors if their pain were under-treated, but would cease this type of behavior once the pain had resolved. This type of behavior raises the possibility that some degree of aberrant, drug-seeking behavior might be considered normative in the context of inadequate pain management (Passik, et al., 2000).

### Conclusions

The results of the extensive literature performed and reported previously clearly demonstrate distinct differences in the concepts related to drug addiction and pseudoaddiction. In addition, it is quite clear that there exists a high degree of ignorance on the phenomenon of pseudoaddiction amongst healthcare professionals.

Simply stated, pseudoaddiction is a misdiagnosis that results from undertreatment of chronic pain. When this diagnosis is made, the medical system has erred. Recognition that patients are frequently harmed by misdiagnosis of addiction should prompt an

aggressive search for undertreatment of pain. Unfortunately, this usually does not happen. Instead, when a patient displays certain behaviors, he is typically threatened with termination of his treatment, rather than questioned about its effectiveness. (Fisher, 2004, p. 25)

Rogers (2004) opines that pain involves an emotional component and therefore suggests that a mental health professional be consulted when a pain patient displays aberrant drug behavior. The current literature on chronic pain generally states that pain has not only a physical and psychological component, but also sociocultural factors that demands a multi-disciplined team of healthcare professionals to effectively manage the needs of the patient (Brown & Folen, 2005). This demands that those healthcare professionals involved, become well versed in distinguishing between drug addiction and pseudoaddiction. It is imperative that healthcare professionals increase their knowledge of pain, addiction, and pseudoaddiction in order to decrease the desperate drug-seeking behaviors resulting from the under treatment of pain.

#### Implications for Practice

Drug-seeking behaviors are not always indicative of drug addiction. Non-critical acceptance of this behavior as a sole diagnostic criterion of drug abuse or addiction ensnares pain victims forced to engage in these risky behaviors only by their yearning to live their lives pain free (Fisher, 2004).

The results of the extensive literature review encompassing case reports and survey studies and the proposed quantitative study as proposed in this paper should serve as a catalyst for any healthcare professionals working directly or indirectly with pain patients displaying aberrant drug-seeking behaviors to not only understand, but clearly distinguish between pseudoaddiction and drug addiction.

Individuals in pain have the right to expect that their complaints of suffering be taken seriously by healthcare professionals who demonstrate a level of competency in both pain assessment and pain management. In addition, they have the right to expect any treatment adjustments necessary to address lingering pain. In this writer's opinion, the under-treatment of pain as an outcome of fear or ignorance on the part of the healthcare professional is a crime. Every individual in pain has the right to any and all treatment options in their quest for an improved quality of life.

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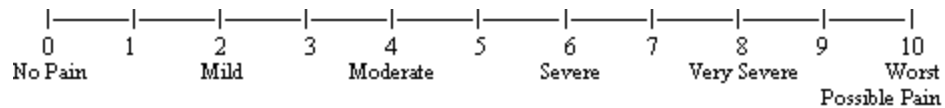
## Appendix A

### Pain Assessment Tool

#### Numeric Rating Scale

Mark the place on this line that best describes the severity of your pain.

## Numeric Rating Scale (NRS)









Pain Assessment Scales (2005). Retrieved January 30, 2006, from  
<http://www.partnersagainstpain.com/index>

## Appendix B

## Pain Assessment Tool

## Pictorial Pain Assessment Scale

Which one of the following best describes your pain? (Patient can reply by pointing to the words, numbers or pictures.)

	Scale	
No pain	0	
	1	
Mild, annoying pain	2	
	3	
Nagging, uncomfortable, troublesome pain	4	
	5	
Distressing, miserable pain	6	
	7	
Intense, dreadful, horrible pain	8	
	9	
Worst possible, unbearable, excruciating pain	10	

Pain Assessment Scales (2005). Retrieved January 30, 2006, from

<http://www.partnersagainstpain.com/index>