

New Ways to Define Conditions Related to Pain and Addiction

Michael Miller, MD

Pain, substance use, and addiction are all health conditions that are receiving increasing attention as we enter the 21st century. This is a good trend, particularly because of the disproportionately small amount of attention these conditions received in medical education in the 20th century compared to their prevalence in clinical settings. Addiction to alcohol and drugs other than nicotine, for instance, has been estimated to have a lifetime prevalence of 10% in every adult in America, of 20% in every adult who receives outpatient medical care in America, and of 30% or more in every adult hospitalized in America—but the proportion of medical and nursing school curricula devoted to addiction is closer to 1%. Clinical responses to these conditions have been suboptimal, therefore, not only because of disinterest or even scorn (deriving from the widespread stigma in our culture that these topics carry), but because of ignorance on the part of some caregivers. Many clinicians have not had the undergraduate or continuing medical education in

these topics to provide them with adequate clinical tools or even adequate theoretical constructs. In an attempt to improve clinicians' basic understanding of concepts, and to address some of the complexities clinicians face when pain and addiction may co-exist, 3 professional societies have come together to prepare a joint statement entitled "Definitions Related to the Use of Opioids for the Treatment of Pain."¹ Acting as the Liaison Committee on Pain and Addiction, representatives from the American Pain Society (APS)—a multidisciplinary organization, the American Academy of Pain Medicine (AAPM)—a medical specialty society, and the American Society of Addiction Medicine (ASAM)—another medical specialty society, developed this joint statement. The statement addresses the tolerance and physical dependence that may result from the use of potentially addictive substances in patients with chronic pain, while acknowledging that tolerance and physician dependence are not identical to addiction.

Several points are worth emphasizing. Modern Americans—including policy makers and health care professionals—have been acculturated to think negatively of persons with addiction, and this is largely because when

people hear the word 'addiction,' what first comes to mind is illegal drug use.² Increasingly, many health writers appreciate that a political process determines whether a drug is legal or illegal and thus may be culturally-based and vary from jurisdiction to jurisdiction; lately, so have many moviegoers, as screenwriters are focusing on this contemporary topic. The fact that use and addiction are very different conditions, however, escapes most people. It has been aptly stated that substance use is a behavior that can be prevented, and addiction is a chronic disease that can be treated. Thus, the use of substances is an acute behavioral event—which can obviously be repeated multiple times—and substance use, in and of itself, can have benign or pathological outcomes. Addiction is a chronic behavior disorder in which substance use occurs repeatedly despite adverse consequences of previous use, and which occurs in a pattern that is not consistently controlled by the patient. It is a chronic illness that, therefore, has a waxing and waning clinical course, is usually progressive, but by definition involves periods of remission followed by periods of relapse (or, in the terminology of other chronic diseases, periods of re-occurrence of active signs or symptoms). Addiction is a chronic illness with characteristic clinical features, a

Doctor Miller is the director of Behavioral Services and medical director of Adult Addiction Services at Meriter Hospital in Madison. An assistant clinical professor at the University of Wisconsin Medical School, Dr. Miller is also an AMA Alternate Delegate and SMS member.

course and prognosis, and, in its active phases, involves substance use in amounts or for durations greater than the user intends, greater than the user's physician (who may have prescribed the substance for the patient) intends, greater than that required for the desired effect, and sufficient to produce undesirable consequences.

The patient with pain who uses opiates is certainly a sub-

frequently-manifested features of addiction.⁴ Only in the 1990s did the American Psychiatric Association revise its diagnostic criteria for 'substance dependence' (its term for the condition of 'addiction') to point out that 'substance dependence' can occur with or without features of physical dependence, and nosology should specify whether or not the independent feature of physical dependence is present or

tions, who asks for a dosage increase and is terrified at the prospect that opiates will no longer be supplied by his physician, is not necessarily a drug-seeking addict. But such patients' experience with health care professionals who label them, openly address them with scornful labels in emergency medical care settings or other clinical settings, and shape their clinical decisions based on stigma, scorn, and ignorance, may lead them to adopt protective behavioral responses that increase the likelihood that health care professionals will view them as not-the-usual patient.

Since the use of opiate analgesics is so important to patients, is such an effective medical intervention, and is so widespread in medical practice, all prescribing physicians should have the best possible knowledge base about their effects, the ability of these agents to contribute to cases of addiction, the relative infrequency of addiction in patients given chronic opiate analgesic therapy, the differences between physical dependence and addiction, and the differences between addiction and pseudo-addiction. Familiarity with the joint statement from the Liaison Committee on Pain and Addiction can be a step in reducing ignorance about these complex issues.

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stance user. Interestingly, although the government classifies opiates as 'controlled substances', whether opiate use constitutes 'illegal drug use' depends on whether use is authorized by a licensed prescriber, and whether the patient's use conforms to the prescriber's instructions. A patient who is a regular user of opiate analgesics may be a patient with addiction, but most often is not. A patient who is a regular user of opiate analgesics may be a patient with tolerance to the analgesic and other effects of opiates, and may experience withdrawal symptoms when doses are reduced or missed, and thus may have a physical dependence on opiates. But, as the joint statement from the APS, AAPM and ASAM makes clear, physical dependence and addiction are not identical. Confusion between the two stems from medical nomenclature itself—through at least the 1970s, the presence of physical dependence (tolerance and withdrawal) was considered a necessary criterion for the diagnosis of addiction.³ Throughout the 1980s, tolerance and withdrawal were considered central,

absent in a case of 'substance dependence.'⁵ Clinical practice in addiction medicine suggests that roughly half of alcohol, nicotine, and other drug addicts manifest physical dependence to their drug; roughly half do not.

So the patient with physical dependence to opiate analgesics must be looked at differently than has been the custom in American medical and nursing practice. The development of tolerance is an expected physiological outcome of regular opiate use. It may be a sign of the existence of addiction, but usually is not. No addict should be treated with scorn, but we know that stigma persists in America—and in its hospitals and clinics. The scorn, or fear, or therapeutic pessimism that is often manifested through conscious or unconscious behaviors and comments about addicts has no place in clinical interactions with chronic-pain patients treated with chronic opiate analgesic therapy who manifest the expected physiological processes of tolerance to and withdrawal from (physical dependence) their opiates. The patient who is preoccupied with his pain medica-



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