

The 'opioid crisis' – a psychological perspective

Perspective

Are we throwing the baby out with the bathwater? We often do that when there is an event called a 'crisis.' We attack symptoms. The government makes policies that are harmful to a large segment of the population and they just don't get it. Here are a few statements from respected journals: The truth about the US 'opioid crisis' – prescriptions aren't the problem; Opioid Addiction Is a Huge Problem, but Pain Prescriptions Are Not the Cause; Cracking down on highly effective pain medications will make patients suffer for no good reason; overdosing on numerous drugs is an epidemic because millions live in a world without hope, certainty, and structure. Lewis,¹ a neuroscientist and author on addiction, said that the overdose epidemic is real and, in fact, it is unmistakable across the globe. It is driven by the illicit or illegal use of drugs but if moral panic leads to many more people in severe pain, 'that would be a disaster.' He points out that the current "opioid crisis" is not the same thing as an 'overdose crisis.'

One of the striking pieces of datum is that the leading cause of death for Americans under the age of 50 is drug overdose. About 63 percent of those people were using a combination of drugs or drugs and alcohol and most of them were involved with illegal drugs like heroin. As for overdosing on prescription drugs, methadone and Oxycontin were at the top of the list and are acquired in illegal ways. According to Lewis,¹ "The most bellicose response to the overdose crisis is that we must stop doctors from prescribing opioids." Hmmm..There was an under prescription crisis in most of the 20th century. Chronic and severe pain was undertreated. Think about people with cancer who just had to suffer. Policies did not ease up until the 1970s and 1980s as far as prescribing effective pain medicine due to an opioid scare that was highly publicized. It is true that between 1999 and 2011, the rate of opioid pain reliever drugs being used in this country multiplied exponentially. In fact the consumption of oxycodone increased by nearly 500 percent. It is important to understand that the overdose rate quadrupled during those years, according to the CDC. Opioids are extremely addictive because they make functional and structural changes in the region of the brain that controls and mediates feelings or affect, impulse reward and motivation. People can become addicted to these drugs when they have been prescribed for reducing legitimate pain. In one study reported by the National Survey on Drug Use and Health, it was revealed that 4 out of 5 heroin users began with opioid use for legal reasons and then switches to heroin because it is cheaper and more easily accessed. There are certainly deaths caused by opioid addiction and overdosing. The National Institute on Drug Abuse suggest that more than 115 people die every day in this country after overdosing on opioids, including prescription pain relievers, heroin and fentanyl, a synthetic opioid.² The NIH² reported these data:

1. About 21 to 29 percent of patients who are prescribed opioids for pain misuse the drugs.
2. Between 8 and 12 percent of those folks develop an opioid use disorder.
3. Opioid overdoses increased 30 percent between July 2016 and September 2017.

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Richard Boudreau

Department of Maxillofacial Surgery, Loyola Marymount University, USA

Correspondence: Richard Boudreau, Department of Maxillofacial Surgery, Loyola Marymount University, California, USA, Email rboudreau@lmu.edu

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4. Opioid overdoses in large cities increased by 54 percent in 16 states.
5. About 80 percent of people who use heroin firsts misuse prescription opioids.

Szalavitz³ reported that a Cochrane review of opioid prescribing for chronic pain revealed that among those who were well-screened for drug use only one percent developed new addictions - one percent. Another study of 136,000 opioid overdose victims who were treated in the emergency room found that only 13 percent had a chronic pain condition. That means the majority of those who were treated were not those who had a legitimate prescription for pain. Rather, they were people who acquired the drug illegally. Public health officials have described an unprecedented increase in morbidity and mortality associated with the use of opioid pain relievers. The attempts to address this situation have focused on reducing nonmedical use of these drugs. Kolodny⁴ argues that the need for treating opioid addiction has been overlooked. Evans⁵ added to this with his statement: "there is a war on opioid in this country---and on the people who prescribe them." Szalavitz argued that the policies and steps to limit prescribing opioids for pain control are harming patients who suffer such severe pain all or most of the time. An overwhelming majority of those who are prescribed opioid for pain use the drugs properly and responsibly. A review of over one million insurance claims revealed that less than five percent of those patients misused the drugs and they were getting prescriptions from multiple doctors. In other words, the government is throwing the baby out with the water! Kelvey⁶ tried to provide some information and data for today's scientists and the public in general. He points out that this is not the first opioid epidemic. In the late 19th century, there was a humongous wave of addiction. It happened when physicians were introduced to morphine and what it could do and how it could help people. They prescribed it for everything. It was a blessing for those people who suffered with pain. There was heroin cough drops and toothache medicine that contained cocaine. The advertisements for these products were vast and impressive. The fact is that the medications prescribed by doctors contained very little of those drugs, not enough to bring about addictions.

There were no laws or regulations. The Harrison Narcotics Act of 1914 was the first federal law to regulate certain drugs like cocaine. Some states had some laws but they were not part of the criminal codes, they belong to medical/pharmacy regulations. Further, the laws were not enforced. The fact is that opium has been used for medical purposes for at least 5,000 years. Papers were written in

1550 B.C. that described how to prepare and use opium in Egypt. Hippocrates discussed the use of opium in 460 B.C. Merck and Company commercially manufactured morphine in 1827. Lacking these opioids, surgery would have been impossible to perform. With all of today's publicity, policies, negative statements, etc., doctors have been afraid to prescribe opioids for several years. Many are simply refusing to prescribe any of these drugs. If physicians refuse to prescribe the pain medicines, what happens to cancer patients, patients with acute fractures, major surgery, and the millions in pain that they can hardly bear? No matter what is happening, the medical profession is neglecting their patients and their needs. Doctors are turning away from helping; they are ignoring their patients' cries for help. They are refusing to accept responsibility for the comfort of their patients and that is in direct opposition of the medical code of ethics. These doctors are being unethical. Worse is the fact that physicians are not well trained in medications in how drugs relate to each other or affect each other and they do not know about the changes in anatomy and physiology as they relate to drugs. Evans argues that doctors need to be experts on the drugs they prescribe. It should be prescribers of opioids that should be leading the charge on appropriate and safe use of opioids. Instead, too many of these people are looking the other way rather than standing up for the patients who really need these drugs and without them, these patients suffer horrendously. It is our moral obligation to know and discuss pain management and get these drugs to those who really need them instead of allowing those people to suffer. Of course, it is up to doctors to also police the profession and identify those who abuse the prescribing duty.

It is necessary to target the real risk factors for addiction. These are "child trauma, mental illness and unemployment." These are manifested in data. For instance, at least half the people who have opioid addictions have a mental illness or a personality disorder. Two-thirds of people with opioid addiction have experienced at least one traumatic child experience. Further, the greater a person's exposure to different types of traumas, the higher the risk becomes. They turn to drugs to self-medicate if they do not get help. Other risk factors for addiction are economic insecurity, poverty, unemployment, social marginalization, lack of structure, and hopelessness. Heroin addiction rates among people who earn less than \$20,000 per year are 3.4 times higher than in people who make over \$50,000. The collapse of the middle class in this country has been accompanied by a direct rise in all types of addictions and especially addiction to opioids. This recent crackdown on prescribing opioids will not solve the problem. It will just make matters worse unless and until the real causes are addressed. As long as there is distress and despair, some people will seek chemical ways to feel better. These folks need to be guided to a healthier way to self-medicate. If not completely healthy, at least guide them towards less harmful ways. It is also imperative to reach children before they develop these types of desperation feelings. Weir⁷ reported there are effective ways to treat opioid disorders. The first line of treatment is medical and psychologists are critical as part of the team treating this addiction. The very first thing is to treat opioid dependence as a chronic health problem, a little like depression is treated. Like other addictions, this is one the patient will have to manage their entire lives. Patients are prescribed a substitution such as methadone or buprenorphine that provide some of the good feelings as opioids provide. These reduce the patient's cravings and reduce withdrawal symptoms and can be prescribed through a clinical program or the patient can take them at home. These substitution approaches gets the patient out of the constant need and craving for opioids and that will allow the psychologist to work with the person.

Psychological interventions can be promoted and implemented during this time. Some possibilities include cognitive-behavioral therapy, family therapy, marital therapy, and vocational counseling.⁷

The therapist will need to determine which intervention approach would be most appropriate with each patient. We know that cognitive behavior therapy has a strong evidentiary basis for changing behaviors in the patient. There is no definitive empirical evidence to support one methodology over another in opioid addictions. One set of investigators found that heroin users and prescription opioid users had different responses to cognitive behavior therapy. There were no differences in outcomes between heroin users who used buprenorphine alone and those who received drug and cognitive behavior therapy. On the other hand, among those who abused prescription opioids those who were involved in cognitive behavioral therapy had more than twice the mean number of weeks of abstaining from drugs compared to the group who were exposed only to medical management of the addiction. Considering the patient's needs and situations, family or marital counseling can be very helpful in repairing relationships that have been damaged through substance abuse. Regardless of the type of intervention, experts remind therapists that respect and trust must be the base of the relationships. Some therapists suggest that the 12-Step program has some benefits and can be an advantage in terms of the community. There is sufficient evidence that psychologists are making a dramatic impact on the opioid crisis. They were instrumental in designing different contingency management programs, for instance. In these programs, participants earn rewards for staying off whatever is their drug of choice. The rewards are prizes or vouchers that can be redeemed for something, like movie tickets. In another type of program, patients earn privileges like the right to take home doses of the subsisted medicine. Recently, most of the opioid substitution programs are using contingency management like strategies. The bad thing is that the places that use these contingency management programs fail to follow the rules. They do not administer and execute the program as it is intended. The correct way is to have drug testing frequently and provide the reward immediately.

One of the things that psychologists could do with this issue is to reach out to physicians who might be thinking about treating patients who have opioid dependency. Psychologists and physicians can coordinate and work together. For instance, doctors can get waivers to provide buprenorphine medications for these patients. At the same time, psychologists can be working with patients through therapeutic interventions. If more physicians provided these kinds of treatments, it could really make a real difference, especially in rural areas where there are so few resources. At this point, physicians have been very slow to consider these programs and apply for the needed waivers. One barrier could be that many doctors do not know where to refer opioid patients for treatment such as counseling. Psychologists can provide this information simply by sending notices to local physicians and talking with them to explain what the psychologist would do. For instance, psychologists could educate physicians about the symptoms of opioid addiction. Some of the signs include sleep problems, changes in appearance, problems with family and friends, physical withdrawal, depression, and failure to fulfill obligations. Psychologists can join physicians in educating the public about opioid addictions. Not that many people really know or understand this particular disorder. One important point is to education the public on the same use of opioid drugs. According to many, this is far better for the public than is trying to preach abstinence. Overdoses lead to death, not the simple use of opioids. There needs to be a refocus on this issue. The opioid

"crisis" is not a 'crisis' at all. Overdosing is a problem. The data are rather clear—the overwhelming majority of patients who receive opioid prescriptions for their severe pain do not abuse this drug. Rather, it is those who obtain this drug illegally that overdose. Further, the data are very clear that there are very few opioid deaths; these deaths were brought on by combinations of drugs and/or alcohol. An overwhelming majority of opioid takers do not abuse the drug nor do they become addicted. This is a made up 'war' and one that is hurting thousands of people who cannot get the pain medicine they need. Opioid use isn't going away, nor should it. These medications have been with us for centuries because they relieve pain and enhance human experience.

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Conflict of interest

The author declares that there is no conflict of interest.

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