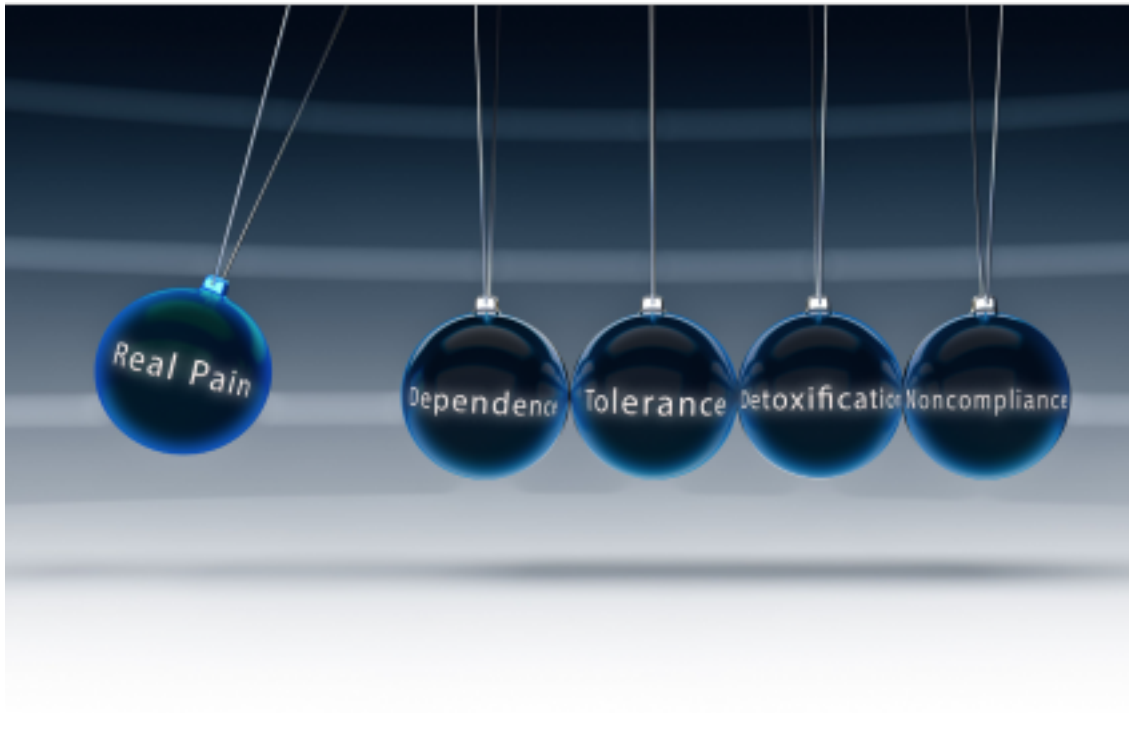


The 5 Most Misunderstood Terms in Pain Medicine

A pain expert offers perspective on several common terms that are widely used by pain practitioners but often are misunderstood by professionals, patients, the general public, and the media.

By [Jennifer P. Schneider, MD, PhD](#) [1]

I am happy to offer a perspective on 5 words or terms that are often used in reference to medication use and abuse, but are often misunderstood and incorrectly applied in clinical care. A consistently correct use of these terms will improve care, lessening a breakdown in communication.



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1. Real Pain

Too often, people believe that pain is valid only if it has a known cause, such as a burn, broken bone, compressed disk, or arthritic joint. What about headaches? Low back pain? Phantom limb pain? These pain-producing conditions are widely accepted as real, yet the actual source of the pain is not visible or readily evident.

It is now understood (and validated by functional magnetic resonance studies)^{1,2} that pain may result from damage to tissue or nerves and/or manifest with psychological aspects such as post-traumatic stress disorder, any and all of which may produce pain that is very real.

In 2011, the [Institute of Medicine](#) [3] published a paper on pain in which the authors stated: “Our committee recognizes the need for a transformed understanding of pain. We believe pain arises from the nervous system but represents a complex and evolving interplay of biological, environmental, and societal factors that go beyond simple explanation.”³

This view was reinforced by Davis and Vanderah,⁴ who made a case for approaching pain differently as “a new way of thinking about pain that occurs in the absence of a pathophysiologic process or injury that may alter our approach to conditions like fibromyalgia. Clinicians theorize that a functional change in the central nervous system (CNS) may occur in response to certain emotional states or traumatic experiences (eg, domestic violence, war, accidents). When such experiences occur, mildly painful stimuli may be amplified and processed through highly sensitized, dysregulated, ramped-up emotional and somatosensory pain circuits in the brain. Adverse childhood experiences (eg, physical abuse, sexual assault) can lead to long-term changes in the nervous system circuitry, particularly in pain processing.”

The bottom line: All pain is real, whether it’s physical and/or psychological, whether the source is evident or not. Instead of telling patients that the pain is “in your head,” we should be explaining that the pain is likely resulting from an overexcited nervous system, which is not unusual when pain becomes a chronic condition.

2. Dependence (Not Addiction)

Many years ago, dependence on a drug was understood to mean that taking the medication was a physical necessity. However, physical dependence has come to reflect a state in which the body responds to chronic use of a drug such that when the medication is stopped suddenly, a specific set of symptoms, or withdrawal symptoms, develop. Some withdrawal syndromes—for example, an abrupt discontinuation of corticosteroids—can be serious or even fatal, while other experiences, such as ending the use of opioids, may be very uncomfortable but are not life-threatening.

Some drug classes that produce withdrawal symptoms when stopped abruptly are potentially addictive (eg, opioids, benzodiazepines, alcohol), while other medications (eg, prednisone, paroxetine) are not associated with abuse or addiction. Simply put, physical dependence is not the same as addiction, nor do these physical responses automatically go hand in hand.

Furthermore, a [physical dependence](#) [4] is not necessary to make a diagnosis of addiction, although most addictive drugs can also produce withdrawal syndromes when stopped suddenly. The way to avoid withdrawal symptoms is to taper or wean the patient off the medication gradually. Tapering also permits the body to adjust slowly and to return to its prior physiological condition. For example, reducing the dosage of prednisone permits the body time to resume production of endogenous steroids.

Confusion Between Physical Dependence and Addiction

Addiction, by contrast, is a different phenomenon from physical dependence and is defined primarily by psychological criteria. Its main elements are:

- Loss of control, or compulsive use. The individual takes more of the medication than intended and has difficulty deciding not to use the drug.
- Continuation despite significant adverse consequences, such as relationship problems, medical side effects, or legal problems.
- Preoccupation or obsession with obtaining, using, and recovering from the effects of the substance, so that the quality of life diminishes.

Why do most people, including most health professionals, erroneously believe that addiction will occur in most patients who are treated with opioids for more than a short time?

The reason may originate from publication of the American Psychiatric Association’s 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which gave the disease of addiction a new name: dependence.⁵ Patients with heroin and other opioid addictions have since been labeled as

opioid dependent. Not surprisingly, over the next 20 years, drug addiction became widely known as drug dependence, and patients who were prescribed opioids for chronic pain were widely stigmatized because their physical dependence was misinterpreted as addiction.

In 2013, an attempt to fix this misperception took place when the DSM-5 was published.⁶ In this newest edition, the term for opioid addiction/opioid dependence was replaced with opioid use disorder. Of course, confusion about the use of the term “dependence” lingers.

Is There a Solution?

The best way forward is for clinicians to stop using the term “dependence.” Instead, consider whether it is necessary to communicate that the patient is physically dependent, in which case the preferred term would be “physical dependence.” When speaking to a patient or noting in the patient’s chart that he or she is addicted, it would be clearer to use the term “addiction” or “substance use disorder.”

Clarity would come more quickly if pain specialists used the more precise terminology in research papers and in speaking with the media. The widespread adoption of more correct terminology will result when all avenues of use become consistent.

3. Tolerance

Health professionals often speak about developing “tolerance” to opioids. This concept, however, is rather meaningless because opioids have several physiological and psychological effects—some desirable and others not—that patients may develop tolerance to. These include analgesia, sedation, respiratory depression, nausea and vomiting, constipation, and euphoria. Tolerance may develop to some of these effects but not others, and the possibility of tolerance will vary among individuals.

When speaking of developing tolerance to opioids, it is necessary to define the adverse effect that is up for discussion or under consideration. It is widely accepted that most patients will develop tolerance to sedation and nausea rather quickly, within a couple of days of starting an opioid. To avoid adverse effects, it is necessary to begin patients on a low dose in order to prevent sedation, respiratory depression, and nausea, from occurring. Tolerance does not usually develop to constipation, which necessitates a discussion with the patient regarding attention to dietary intervention and a regular bowel regimen to prevent (or treat) opioid-induced constipation. Tolerance to the euphoria effect develops rapidly, which drives addicts to demand to have their dose increased.

Development of tolerance to the analgesic effect of opioids remains controversial. Most people (clinicians and patients) accept that tolerance to pain relief will develop, although it may occur over months rather than days. A minority of clinicians, however—who have actually provided long-term opioid treatment to their pain patients—have found that the majority of such patients can be maintained on the same dose, whether high or low, for years, unless their disease worsens, as with osteoarthritis, for example, or there is a new source of pain.⁷

As mentioned above, it is desirable to begin treatment of chronic pain with a low opioid dose in order to minimize adverse side effects, and then the dose can be titrated up quickly until adequate analgesia is reached. At that effective dose, however, it is common for some patients to return with complaints of increased pain. Many prescribers erroneously conclude that the patient has developed tolerance to the analgesic effect of the opioid. Remember, however, that the 2 main goals for treating chronic pain are to decrease pain and to increase physical function. When the pain decreases, patients will (hopefully) increase their activity, but increased movement is likely to initially produce increased pain. A responsible response on the part of the clinician is, therefore, to increase the opioid dose to permit continued activity. As the muscle strength is restored, pain can be expected to decrease over time.

This scenario offers a reasonable explanation of the need for an increase in the dose as the patient’s

activity level rises. Indeed, if a patient's pain level improves but the function does not, then this is not considered a good outcome.

As such, it is best to obtain a baseline assessment of the patient's function at the first visit and to repeat the functional assessment at each follow-up, including documentation of specific or routine activities. Simply documenting that "function has improved by 40%" or "function is now 6/10" is insufficient to determine progress. With more specific documentation, a physician can note whether a request for more pain medication is related to an increase in activity, rather than being a result of intolerance to analgesia.

4. Detoxification (Detox)

When a pain practitioner decides to wean or taper a patient off an opioid, it is common to find a comment that the patient has been "detoxed" in a patient's chart or in the provider's speech. Yet detoxification is defined by the Drug Enforcement Administration (DEA) as getting addicts off their addictive drug, which requires specific licensing, as in an "X" waiver on a clinician's DEA permit.⁸

As the DEA website states: "Physicians registered with the DEA as practitioners who apply and are qualified pursuant to DATA (Drug Addiction Treatment Act) are issued a waiver, and will be authorized to conduct maintenance and detoxification treatment, using specifically approved schedule III, IV, or V narcotic medications. DATA waivers are only granted to qualified physicians. Hospitals and mid-level practitioners do not qualify under the DATA."

When a chart has a note that a patient was "detoxed," the legal implication is that the clinician was treating an addict, a specifically defined legal action, rather than working with a patient to better manage the pain. For a clinician who has been treating a patient with a prescribed opioid and decides to change the treatment plan, it is advisable to avoid using the term "detox"; instead, the proper notation would be ["weaning" or "tapering"](#) [5]the opioid.

5. Noncompliance

When a patient reports or acknowledges that a prescribed medication was not taken, or a prescription for physical therapy or a referral to a specialist was not carried out, practitioners may be quick to label the patient noncompliant. A common reaction is to lecture the patient to do as instructed.

As Weiner and Schwartz wrote in [Listening to What Matters](#). [6]⁹ responding to a patient's decision not to follow through with a prescribed treatment with an order to do so is an example of a fundamental attribution error. "This error is a failure to consider the complex situational reasons that a person may behave irrationally or inappropriately, and instead attributing their behavior to a fundamental flaw in their character," noted the authors.⁹

In this circumstance, the advisable approach is to inquire of the patient why the prescription or a referral was rejected. There is often a legitimate reason, one the clinician may be able to address, such as finding a less expensive alternative or a specialist located closer to the patient's home, a fear of addiction, and so on.

To call the patient noncompliant before ruling out plausible explanations is to needlessly stigmatize the patient. Since noncompliance is a common reason to withhold opioid prescriptions, labeling the patient as noncompliant may just increase any anxiety about the possibility that the clinician may decide to stop addressing the pain. Lastly, anxiety is known to increase pain, so attribution errors can do the opposite of lessening the patient's pain.

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