BY PAUL J. FINK, M.D.

Fink! Still at Large

A study of patients prescribed opioids for chronic pain showed that psychiatric factors can raise the risk of misuse. What has been your treatment approach in helping these patients?

Treatment of drug and/or alcohol addicts is extremely difficult for those psychiatrists not specifically trained to handle such patients. Let me start by describing two patients with whom I failed miserably because, in my commitment to addressing the symptomatic side of the disability, I did not address the addiction.

The first case involved a 41-year-old single man, who was a son of very rich parents. The patient seemed to have had a lifetime of debilitating depression. He appeared attached to his elderly mother and had no friends, work, or real source of pleasure. All of that should have been enough for me to delve into the possibility of addiction, but he did not offer the information and I did not ask.

He described a terribly abusive childhood, mostly at the hands of his alcoholic mother, who beat and humiliated him constantly and essentially blamed him for everything—since his brother could do no wrong. The most pathetic sentence I can remember from his treatment was: "Every day when I got home from school, I tried to get from the front door to my bedroom in the hope that I would not rouse or encounter my drunken mother."

He ended treatment by going into an alcohol rehab center.

The second case was even worse, because I knew when I started treating this patient that he was an alcoholic. He was a 42-year-old lawyer with a history of many rehab admissions and attempts to stop his use of drugs and alcohol. I was persuaded to take him into treatment by his father, whom I had known casually more than 40 years earlier.

His father, who was extremely intrusive, domineering, and controlling, took his son into his law practice. The father was such a hovering and demanding presence in his son's life that the treatment started by my attempting to help the patient separate from him. This turned out to be extremely difficult, and I was not paying enough attention to the drinking.

From time to time, his father would call to scold me and tell me about a drunken episode that had occurred over the weekend. I was so resentful of the father and committed to the patient that I did not take a strong, objective view of the regression as a good treater of an alcoholic would have done. Instead, I took a softer psychotherapeutic approach that was not absorbed in a positive way by the patient. I was going to be a better, kinder, gentler father figure for this patient.

Clearly, this is antithetical to the best treatment for an addict. He, too, left therapy for another tour through a rehab center, and I never heard from him again. I would like to believe that his silence stemmed from his father's rage at me rather than his own disappointment with my care.

Both of those cases illustrate the need for a general psychiatrist to have specific training in caring for the addicted patient.

I hope that today's residents fulfill the requirement to learn about addiction psychiatry. It should be something every practicing psychiatrist should learn and know how to do. The most important question to be asked is whether the use of drugs and alcohol is primary with anxiety and/or depression superimposed on the addiction because of the failure, dissipation, and uncontrollable craving. Or are the anxiety and/or depression primary, and is the patient using drugs and/or alcohol as self-medication?

Many patients whom I have evaluated start drinking early in adolescence because of the posttraumatic stress disorder (PTSD) suffered as a result of serious physical or emotional abuse as a child. I believe the first patient's problems were at least partly a result of his serious abuse as a child. But there is also the genetic element that cannot be discounted.

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It is important that the clinician try to make the distinction as part of the patient's evaluation so that he knows what direction to take in the treatment. Regardless of the answer, the initial care must be directed to the cessation of substance use.

For the nonaddict, the most difficult thing to understand is the depth and extent of the craving. Because brain changes clearly take place in the addict that make this craving a biologically driven reality, it is very difficult for the patient to "just say no." Willpower is an insignificant force, compared with the attraction of the patient's substance. We all know former smokers who, even though they have not smoked for 20 years, still desire a cigarette—especially when they are in the company of someone who is smoking. Similarly, the drug and alcohol addict cannot really control this desire. That's why Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) are so important and should be part of every treatment regime. The key to AA/NA, in my opinion, is the sponsor. The sponsor is someone who is a mentor, guide, and coach who is available 24/7 so that the user can call upon that person to help them suffer through the attack (of desire) and not succumb to it.

There are many elements to AA/NA, but the secret is in the meetings—for beginners, daily—which brings the addict out of seclusion and into the presence of many others who are suffering from the same disorder and share their experiences with the group. At least the naïve addict knows that he is not alone, and while shame and humiliation might initially stop him from "sharing," he listens to the others and recognizes his own pain as he hears about the pain suffered by others.

Finding a sponsor is critical, and for some, the sooner the better. The psychiatrist or psychologist cannot do what the sponsor can do. Some psychiatrists try to be constantly available to the addicted patient but always fail, because such availability is not really part of their general modus operandi. Such expectations only serve to put a hostile distance between the doctor and the patient, and will clearly lead to failure, for which the doctor generally blames the patient.

There are several forms of iatrogenic precipitation of addiction. The first deals with actions that I feel are appropriate: the proper prescription of opiates to patients with severe and unremitting pain, most often in patients with advanced cancer. Unfortunately, some physicians still underprescribe opiates for their patients, because they do not want to cause them to be addicted (even though in many cases, the condition is incurable and the patient is going to die relatively soon). This absurd idea is sadistic on the part of any doctor who would deprive such a patient of adequate relief of pain for sanctimonious and righteous reasons.

The prescription of opiates for undefined and poorly described pain, e.g., back pain or headache, is an opposite situation. Often, psychiatrists are cajoled into prescribing such drugs for patients who may see a general practitioner or internist very rarely, and without a clear diagnosis of the problem and a determination of whether the problem is physical or mental.

Such determinations often require imaging procedures and/or blood tests that are not part of the psychiatrist's usual practice, and it is easier to prescribe the drug than to worry about the threat of addiction. These psychiatrists often find themselves with an iatrogenically produced addict on their hands and in a real dilemma about how to resolve the problem. We psychiatrists generally are not schooled in how to detox a patient, and it becomes apparent in both of these situations—the patients whose complaint sounds very severe and the patient with less severe pain.

Writing a prescription that says "go to a methadone clinic" is not only inadequate but cowardly, because the psychiatrist would rather not expose himself to criticism over his poor behavior. Once again, narcissism gets in the way of the best interests of the patient.

In the prescription of nonopiates, we are also often too cavalier. Xanax and Valium are highly addictive psychotropic drugs. While I believe that prescriptions for Valium are fewer these days, there is still a lot of Xanax being prescribed, because it is an extremely efficacious drug for people with panic disorder or severe anxiety. Psychiatrists have to be more careful in prescribing psychotropic drugs and try to avoid creating an avoidable problem.

The concept of the addictive personality is important. There are people whose propensity for developing an addiction, whether one that is socially acceptable or one that isn't, is very important because we generally have not considered the factors that contribute to this kind of diagnostic formulation.

The study mentioned in the question above demonstrated that patients with a psychiatric history are at risk for aberrant drug-related behavior if they have chronic pain (Clin. J. Pain 2007;23:307-15). The investigators found that patients who were classified in the high psychiatric group used more drugs and higher doses. The bottom line? A consistent association was seen between psychiatric morbidity and prescription opioid misuse in chronic pain patients.

We as psychiatrists must be acutely aware that factors such as a history of mood disorders, other psychiatric problems, and psychosocial stressors might place patients at risk for misuse of prescription opioids. We often contribute to patients' addiction by continuously prescribing opiates at patients' request without carefully scrutinizing the problem or even thinking twice about the deleterious effects of what we are doing.

"Use caution" and "Have a high index of suspicion" are two expressions we heard often as medical students. This column raises many issues that call those expressions to mind. The addict is often wary and suspicious, certainly distrustful. Much of his energy is exerted in persuading us to write the prescription. As I indicated in the case examples, such patients are often not committed to therapy—which is why I tell residents and students to make sure that a dual-diagnosis patient gets rehab first and then psychotherapy.

In psychiatry, we have two subspecialties that should be fully accepted not only by medicine as a whole and the public but by psychiatrists as well. These are addiction psychiatry and pain medicine. The former is older and better defined. As this column makes clear, this specialty needs to be better understood and incorporated into the full practice of psychiatry with appropriate knowledge of the field as well as the use of trained colleagues to help us navigate what is a significant part of our specialty. This is especially the case in light of the serious problems of dual diagnosis patients and the ever growing problem of prescription drug abuse among teenagers and young adults in our country.

Pain medicine, which is shared with anesthesiology, oncology, neurology, and a raft of specialties outside of medicine (in particular hypnotism), is a growing field. We need to understand this field better so that we can do a better job of treating patients who are in pain and are addicted, and also have a psychiatric disorder. Addiction psychiatry and pain medicine truly demonstrate the complexity of our work as psychiatrists. ■

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