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Introduction to OPIOID USE AND MISUSE

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INTRODUCTION TO OPIOID USE AND MISUSE

Samuel Knapp, EdD, ABPP

This is a reprint of a current home study offered by PPA.



The United States has an opioid problem. Despite nationwide efforts to change prescription patterns, offer alternatives to medical opioid use, and lawsuits against pharmaceutical companies, opioid addiction and opioid-related deaths continue to be unacceptably high. Opioid-related deaths have increased during the COVID-19 pandemic (CDC, 2020).

Effective strategies for addressing this problem include changing prescribing patterns to reduce the likelihood that new patients will misuse opioids, reducing opioids among those who had been inappropriately prescribed opioids, using more nonopioid medications or nonpharmacological interventions to mitigate chronic pain, and treating those who misuse opioids.

The Centers for Disease Control and Prevention (CDC; 2019) estimated that 11% of Americans misused a prescription drug in 2018. In addition, deaths from drug overdoses tripled from 1999 to 2019 and most of the increase was due to deaths from synthetic opioids (Hedegaard et al., 2020). Opioid overdoses are considered one of the deaths of despair (the others are suicide and cirrhosis of the liver), so-called because they have the common factor

of despair. Also, long-term opioid use increases the risk of premature deaths from cardiovascular disorders (Ray et al., 2016) and can diminish a person's quality of life.

The opioid crisis is linked to the quality of treatment for patients with chronic pain, which is defined as "pain that persists beyond the time frame for resolution of the underlying condition" (Palermo & Kerns, 2020, p. 741). About 20% of Americans have chronic pain and 6% have high-impact chronic pain that limits their work activities on most days (Dahlammer et al., 2018). The opioid crisis and associated increases in opioid-related deaths are acute in the areas of the country that are suffering from serious economic recession, reduced employment opportunities, and a diminished sense of hope.

Traditionally, the treatment of pain involved a unimodal pharmacological medical response, even though the prevailing theory is that pain is a biopsychosocial phenomenon. Many blame the opioid problem on the prescribing patterns of physicians who often prescribe opioids for the treatment of pain. Most patients who receive opioids for the short-term relief of pain suffer no significant side effects. A small percentage of patients

prescribed opioids will need them for an extended time (Kroenke & Cheville, 2017), and one in four of those patients will have a long-term struggle with abuse (Boscarino et al., 2010). Health care professionals must help those patients who have developed a dependence on opioids and to ensure that new pain patients receive effective treatments that reduce reliance on opioids.

This home study will briefly review the history of opioid use in the United States, essential information about opioid use and misuse, the role of pain treatment in the opioid epidemic, information on treating opioid misuse, and the relationship of opioid misuse to suicide.

A BRIEF NOTE ON THE HISTORY OF OPIOID USE IN THE UNITED STATES

Opium has been part of human society for many centuries. Archaeologists have found evidence of opium use as far back as 8,000 to 10,000 BCE (Inglis, 2019). Physicians in colonial America frequently used opium to treat a wide range of problems, including coughing, which was often a sign of tuberculosis. Even one of the side effects of opium, constipation, had a therapeutic



benefit in that it could control diarrhea, another common cause of death.

The use of opioids increased during the American Civil War, especially by surgeons who had to remove limbs from soldiers injured during battle. The surgeries were brutal, and effective surgeons were those who could remove the limbs most quickly, thus reducing the likelihood that the patient would die from shock. Many Civil War veterans, both North and South, became addicted to opiates such as opium or morphine (Quinones, 2015).

The introduction of the hypodermic needle to the United States in 1856 further increased the use of opium because it helped patients feel the benefits of the drug more quickly. At the time, physicians lacked effective pharmaceuticals for most disorders; and opiates in patented medicines could be purchased without a prescription. Heroin was introduced in 1898 primarily as a cough suppressant (Courtwright, 2001).

Eventually the physicians who once recommended opiates liberally began to discover that many of their patients had acquired an opium "habit." Those at the higher socioeconomic levels of society who could afford to go to physicians were more likely to develop the opium habit. Those at the lower socioeconomic levels of society did not have the "benefit" of access to physicians and were less likely to develop the habit. The link between opioid misuse and prescribing patterns of physicians would reoccur more than 100 years later.

By 1900, physicians began to have more options for treating disease. By this time, the germ theory could explain many diseases.

Aspirin, another medication to control pain, was introduced in 1899 and the X-ray was invented in 1895.

The 1906 Pure Food and Drug Act required manufacturers to identify the ingredients in their medicines. Many partakers of over-the-counter patented medications learned that they had been taking opiates. The 1914 Harrison Act restricted the use of opium to medical purposes, and in 1919 its provisions were interpreted to prohibit physicians from prescribing opium simply to maintain those who had a habit. The opioid habit of the White upper class gradually became the opioid addiction of the lower classes. During the 1920s, many addicts supported their habit by looking for scraps of copper, lead, zinc, and iron in industrial waste dumps, thus earning themselves the name junkmen or "junkies" (Courtwright, 2001).

ESSENTIAL INFORMATION ABOUT OPIOID USE DISORDERS

Opioid drugs are considered Schedule II drugs, which means that they have a high potential for abuse leading to psychological or physical dependence. Opioids relieve pain by binding on the mu-opioid receptors in the brain that regulate pain perception and feelings of euphoria. In addition, opioid receptors can be found in other areas of the body, such as areas regulating respiration.

The CDC classifies opioids into four categories: (1) natural or semisynthetic opioid analgesics such as morphine, codeine, oxycodone (Oxycontin), and hydrocodone (Vicodin); (2) methadone; (3) synthetic opioid analgesics (such as tramadol and

fentanyl); and (4) heroin. The Food and Drug Administration (FDA) has approved 18 different opioid-based medications.

Tramadol and fentanyl are synthetic, high-strength opioids approved for treating severe pain. Although developed as a prescription drug, fentanyl is now being made and distributed illegally. Some opioids sold on the street are laced with fentanyl without the knowledge of the buyer. Both Michael Jackson and Prince overdosed on fentanyl. From 2013 to 2019, deaths from synthetic opioids increased more than 1,000% (Mattson et al., 2021).

THE SPREAD OF OPIOID MISUSE

The rise of opioid misuse occurred because of an increase in the supply of opioids first through overprescribing and then through the development of easily available synthetic opioids. But supply is not sufficient to create an epidemic. There was also a demand for opioids, especially among those who experienced pain and disability and among those who lived in poverty or had limited job opportunities (Cerdá et al., 2021). Opioid misuse occurs more often in counties in the United States that are economically depressed.

The rise of opioid use has occurred through three waves in the United States. The first wave started in the late 1990s with an increase in the abuse of prescription opioids. Around 2010, the use of heroin increased following efforts to curb the prescription of opioids, and then around 2013, the use of synthetic opioids such as fentanyl increased.

The rise in the use of heroin around 2010



may be linked to dependency initially created by opioid prescriptions. Only 4% of persons prescribed opioids will go on to use heroin (Institute of Medicine, 2011). Nonetheless, given the large number of patients who receive prescription opioids, this could translate into more than 100,000 new heroin users a year. In the last decade, 75% of heroin users reported that prescription opioids were the first opioids that they used, in contrast to the 1960s where 80% of heroin users reported that heroin was the first opioid that they used (Compton et al., 2016). Heroin is more accessible and less expensive than other opioids. It can be snorted or injected, thus providing a more immediate sense of euphoria (CDC, 2017). Heroin is especially problematic because the strength of the drug may vary, it may contain contaminants, and injecting it increases the risk of HIV or hepatitis C infections (Banerjee et al., 2016). Around 90% of heroin users will develop hepatitis C sometime in their lives (Connery, 2015).

The number of heroin users has sharply increased in some states such as West Virginia, Ohio, and Pennsylvania. One man from Middletown, Ohio, stated that “everyone I know is on heroin.” Middletown, which was once proclaimed as an “All-American City” and the heart of America’s heartland, has seen heroin use and overdoses surge (de la Bruyère, 2017). Areas of the country hit hard by the opioid epidemic are likely to have reduced employment opportunities and poverty (Cerdá et al., 2021).

Despite the higher rate of abuse among economically distressed persons, increased heroin use has nonetheless occurred across all demographic groups, including women, those with private insurance, and those with higher incomes. It would not be unheard of to encounter a college-educated, employed, White woman living in the suburbs who is using heroin. One middle-class mother had her adult son die from a heroin overdose. She said, “I no longer judge drug addicts . . . I no longer judge prostitutes” (Quinones, 2015, p. 9).

THE OPIOID ABUSE AND PRESCRIPTION PRACTICES

During the middle to late 1990s, a combination of factors led to the overprescription of opioids. A movement focusing on assessing and treating patients for pain was the immediate catalyst. In 1999, the U.S. Department of Veterans Affairs (VA) started an initiative called “Pain as the 5th Vital Sign” that required physicians to assess pain in each of their clinical encounters. The other vital signs were heart rate, temperature, blood pressure, and respiratory rate. In 2000, the Joint Commission (formerly called the Joint Commission for the Accreditation of Health Care Organizations) required organizations to establish policies for assessing and managing pain (Baker, 2017).

Although these initiatives did not explicitly recommend opioids for pain reduction, it could be argued that an increase in opioid prescriptions would be expected because they were the drugs most widely used to control pain. Physicians were not well trained in how to manage pain. Many were not aware of behavioral interventions for pain or were working in health care environments where patients lacked easy access to behavioral interventions. Also, science had not yet identified the extent of harm from extended opioid use, and pharmaceutical companies aggressively promoted the benefits of opioids to physicians and minimized or denied potential harms.

Sales of opioid analgesics increased 300% from 1999 to 2011. Almost two-thirds of those prescriptions were for short-term therapy (less than 3 weeks; Volkow et al., 2011) and most were for joint or back pain (Voelker, 2017; Young et al., 2020). Although opioid mills increase the availability of opioids, most opioids still come from legal prescriptions written by well-meaning physicians. Online pharmacies have contributed to abuse, especially those that sell unapproved opioid products to patients without adequate instructions for their use or sometimes even without prescriptions (Jaklevic, 2020). While cracking down on opioid mills and online pharmacies is essential, it is not sufficient to curtail the abuse of opioids. The prescribing patterns

of physicians need to be changed to curtail this problem.

Physicians often have idiosyncratic prescribing practices. For example, Barnett et al. (2017) found that emergency room physicians differed significantly in how frequently they prescribed opioids, even when the characteristics of the patients appeared similar. Although the initial prescription written by an emergency room physician might appear to be of limited consequence, in and of itself, it may lead to clinical inertia whereby subsequent physicians continued to prescribe the opioid without adequately reviewing its medical necessity. Emergency room patients treated by high-intensity prescribing physicians had higher rates of long-term opioid use than patients treated by low-intensity prescribing physicians.

Fortunately, the number of prescriptions of opioids is declining. Among Medicare beneficiaries, for example, the overall prescription of opioids declined from 2013 to 2017, although it increased for physicians who specialized in pain management. One interpretation of the data is that more physicians are referring patients with chronic pain to physical and rehabilitation medical providers (Romman et al., 2020).

The increase in the prescription of opioids has been accompanied by an increase in nonmedical or recreational use of prescription opioids. Although only a small minority of patients prescribed opioids will abuse them, some patients are especially vulnerable, including those with a history of substance abuse, uncontrolled pain, emotional distress, or who are adolescents or older adults. Adolescents have an increased risk for harm because the neuroplasticity of their brains and their underdeveloped cortexes make them more prone to impulsive behaviors (Volkow & McLellan, 2017). In 2010, 6% of adolescents aged 12 to 17 had taken controlled pain medications for nonmedical purposes (Young et al., 2012).

Older adults also have a greater risk of misusing opioids, especially if they have a history of depression or substance abuse (Boscarnio et al., 2010). Furthermore, they are more likely to have serious pain, and their kidney and liver functions have

slowed down, allowing drugs to remain in the system for longer periods of time. Nonetheless, no patient is immune from abusing a medication.

Patients who abuse opioids may steal or borrow them from friends or family members, receive prescriptions from more than one physician, or purchase them from drug dealers (Jones et al., 2014). Some older adults with limited incomes may sell their opioid drugs to drug dealers to supplement their incomes (Eaton, 2017). Often drug dealers will solicit or threaten older adults to sell their prescription pills, and then resell them at a much higher price.

Opioid misuse does not show a direct correlation with perceptions of pain, although the perception of pain is one factor that increases the likelihood of misusing an opioid prescription. But the relationship of pain intensity to opioid misuse disappears when controlling for pain catastrophizing and negative affect (Martel et al., 2020). Pain catastrophizing is “an exaggerated negative cognitive orientation toward pain involving magnification of the threat value of pain, helplessness in the context of pain and difficulty inhibiting pain-related thoughts” (Aaron et al., 2020, p. 800). This suggests that pain management programs that address pain catastrophizing and negative affect may reduce opioid abuse.

Patients with polyneuropathy who

a depression, opioid dependence, or have had an opioid overdose than those who received short-term prescriptions of opioids. Nonetheless, the self-reported functional status of long-term opioid users was no better than those who received short-term prescriptions of opioids (Hoffman, et al., 2017). Despite that, many patients and physicians believe that only opioids can control their severe pain, and many patients do not have access to professionals trained in nonmedical treatments for chronic pain.

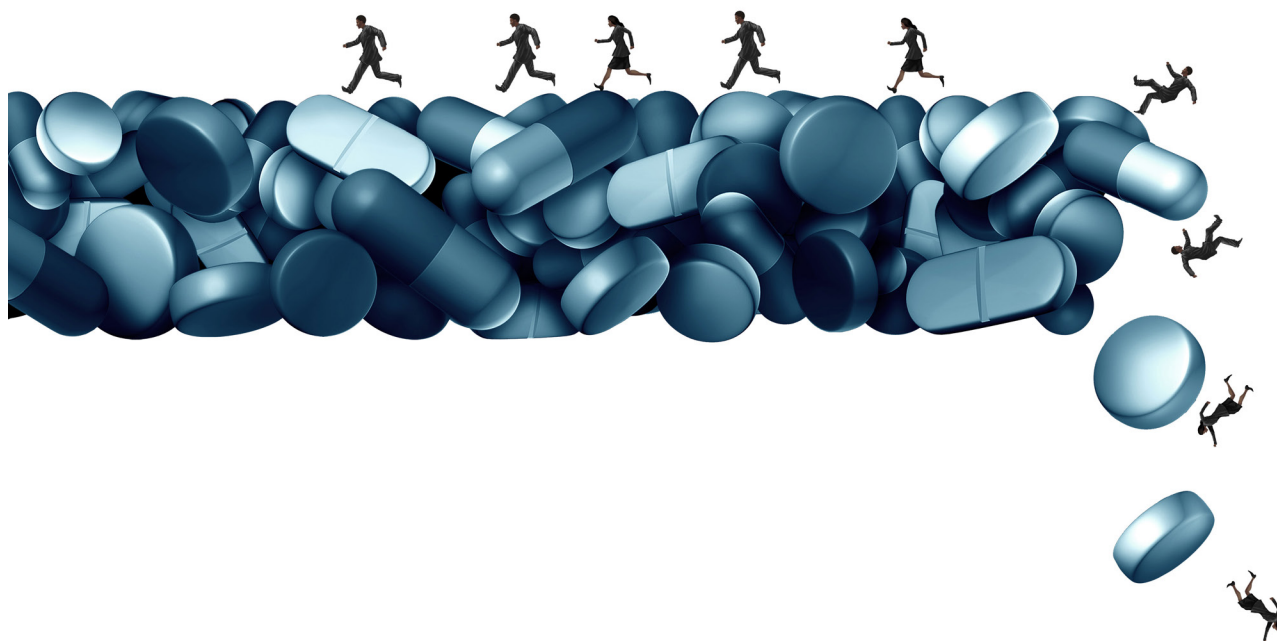
Patient demand may influence opioid prescribing patterns and some patients may believe that only opioids can reduce their pain. Along those lines, Schmagel et al. (2020) found that 94% of the opioid prescriptions for chronic lower back pain went to patients with less than a high school education. One wonders at the causes of this disproportional prescribing pattern. Did these patients have less access to nonpharmacological pain interventions or did they believe that opioids were the only way to reduce their pain?

Physicians often feel pressure from patients to prescribe opioids and simultaneously feel pressure to limit the opioids that they prescribe. At times, it appears that “policy and medicine are at odds with each other” (Webster, 2014, p. 346). According to psychologist Dr. Julie Radico, Assistant Professor at Penn State

feel caught between competing demands. Patients want relief from pain, yet opioids involve health risks and do not always reduce long-term pain” (personal communication, July 5, 2017). The tension between patients and physicians has sometimes resulted in patients threatening or even assaulting physicians who failed to meet their demands for opioids (Webber, 2021).

Probably most of the responsibility for overprescribing opioids rests with pharmaceutical companies who promoted bad science that extolled the benefits of opioids while denying or downplaying their harmful side effects. Some earlier scientific publications claimed that the risk of abusing opioids was very low, even though the science behind those conclusions was weak. One 5 sentence and 99-word letter to the editor of the New England Journal of Medicine (Porter & Jicks, 1980) concluded that “despite the widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction” (p. 123). The letter was subsequently cited 901 times in Google Scholar and was referenced as “extensive,” “landmark,” and “persuasive,” despite its many methodological shortcomings (Jacobs, 2016). In contrast, similar letters to the editor in 1980 were cited a median of 11 times (Leung et al., 2017).

Purdue Pharma, the company that





revenue in 1996, only a few years after their drug was introduced into the market. At one point, OxyContin accounted for 90% of that company's sales. It is alleged that Purdue Pharma gave misinformation to physicians (Meier, 2007), including claims that patients receiving high doses could abruptly discontinue the drug without ill effects (Quinones, 2015). Between 1996 and 2002, Purdue Pharma sponsored 20,000 continuing education programs for physicians that some claimed were primarily advertisements for opioids given with a professional veneer that could pass for continuing medical education (Ohio High, 2017).

The responsiveness of physicians to this marketing campaign may have occurred, in part, because they lacked in-depth knowledge of pain and of the effectiveness of nonmedical interventions for pain. The average physician received 11 hours of coursework on pain management in medical school, although some received only 1 hour (Davis & Carr, 2016). The amount of education they received on substance use disorders was similarly quite low.

MITIGATION STRATEGIES

Risk mitigation strategies can reduce the risk of opioid use disorders. These include monitoring the patient's opioid use, using nonopioid pain reduction interventions, treating coexisting mental health and substance abuse disorders, and avoiding the coprescription of opioids and sedatives. No one risk mitigation strategy is appropriate for every patient or every setting; however, together they can reduce the risk of misusing opioids.

Physicians now use Prescription Drug Monitoring Programs (PDMP), which are statewide databases that collect information on the prescription of controlled substances. They monitor the prescriptions written for patients and track patients who seek prescriptions from multiple providers. Pennsylvania physicians must report on prescriptions of controlled substances to the PDMP by the close of the subsequent business day (Pennsylvania Department of Health, 2017).

The CDC has issued Guideline for Prescribing Opioids for Chronic Pain (Dowell et al, 2016). These guidelines state, among

other things, that nonopioid treatment is preferred for chronic pain, opioids should be prescribed at the lowest clinically indicated level possible, physicians should avoid prescribing opioids and benzodiazepines at the same time, and physicians should evaluate long-term opioid users every 3 months. These guidelines have not been without controversy as some have argued that institutions have been using the guidelines to require practitioners to prescribe low doses of opioids without considering the unique medical needs of each patient (Darnell, 2020) or the fact that prolonged opioid use may increase pain sensitivity.

Also, the FDA has required producers of extended-use or long-acting opioids to institute risk evaluation and mitigation programs (REMS) to reduce the likelihood of serious harm to patients prescribed a drug. These involve educational programs for physicians on the risks and ways to reduce long-term opioid use. One study found that REMS programs reduced prescriptions of opioids and reduced opioid-related mortality in one of the three states studied (Black et al., 2020).

Veterans are prescribed opioids at a rate of seven times more than the American population in general. Consequently, the VA is investing heavily in the risk mitigation strategies reviewed above and it is also requiring long-term opioid users to receive urine screens that will help determine if the patients are also using illegal drugs or if they are not taking the drugs and perhaps diverting them to friends or family members. The VA procedures have reduced the rate of drug overdoses in half from 2010 to 2015 (Gellad et al, 2017).

Although educational programs can reduce the prescription of opioids, a more crucial question is whether the reduction in prescriptions of opioids is occurring while effective replacement treatments for chronic pain are being offered. After all, physicians are more likely to decrease opioids when they have the option of offering effective alternatives for pain to patients, a process known as gain framing (Oldfield & Becker, 2020). That is, physicians can present patients with better options for managing their pain as opposed to only informing patients that

they must take away a drug that the patients believe is helping them.

Fortunately, among outpatient surgeries, the implementation of opioid guidelines has resulted in a decreased use of opioids while keeping pain down and maintaining patient satisfaction with pain management (Allan et al., 2020). One component of the prescribing change has been to focus on educating patients.

WHAT ABOUT PAIN?

Concerns about opioid use disorders risk overshadowing the continuing problem of helping patients manage chronic pain. Von Korff et al. (2016) reported that 14% of patients had severe chronic pain often occurring in multiple locations, and about 20% of these patients were receiving opioids to help control their pain.

Efforts are underway to develop nonaddicting pain-reducing drugs. However, new drugs might not be the only answer. After all, pain can best be described as "multidimensional, dynamic interaction among physiological, psychological, and social factors that reciprocally influence each other" (Edwards et al., 2016, p. T71). The revised standards of the Joint Commission recommend looking at psychosocial risk factors for chronic pain and for exploring nonpharmacological options for pain management (Baker, 2017). A review of integrated care and complementary and alternative medicine (CAM) has found preliminary data suggesting that both can reduce opioid use (Hassan et al., 2020). More specifically, interventions that help patients to manage their affect and to reduce pain catastrophizing have reduced the perceptions of pain and the use of opioids (see for example, Crouch et al., 2020; Gibson et al., 2020).

Behavioral interventions are hindered by the lack of qualified persons to administer them and by reimbursement patterns that favor pharmacological interventions. It is true that behavioral interventions do not work well for all patients with chronic pain, but "imperfect treatments do not justify therapeutic nihilism" (Kroenke & Cheville, 2017, p. E1).

SOCIAL DETERMINANTS OF ADDICTION

Although it is important to address the individuals who are at greater risk to misuse opioids, a comprehensive national strategy would also have to look at the social determinants of addiction as well. Americans with limited job opportunities or avenues for coming out of poverty risk experiencing despair and turning to opioids.

PROFESSIONAL PSYCHOLOGISTS AND OPIOID USE TREATMENT

Some psychologists, such as those who work in chronic pain centers or in the treatment of substance abuse, regularly encounter issues surrounding opioid use or abuse. But even psychologists in a general outpatient practice will likely encounter patients who are taking opioids, are abusing opioids, or had abused opioids. This section reviews some essential information that generalist outpatient psychotherapists should know about opioids and opioid use disorders and how to respond when they are treating patients who appear to be abusing opioids.

SCREENING ALL PATIENTS

It is recommended that outpatient psychologists ask all their patients about the pharmaceuticals (prescription and nonprescription, legal and illegal) that they are taking, any history of substance abuse, their current physical health (including any chronic pain), and legal history. An arrest involving drugs or a DUI raises concerns for a substance use disorder. Many psychologists include such questions on a form given to patients before treatment begins, but it is prudent to follow up if the responses raise any concerns.

PATIENTS TAKING OPIOIDS

Psychologists will encounter patients who have been prescribed opioids appropriately for the short-term relief of pain. Most of these patients will not abuse these drugs. Also, psychologists will encounter patients who have been prescribed opioids for chronic pain. Although the effectiveness of opioid prescriptions for the long-term control of noncancer pain is not well documented, many competent physicians believe that a minority of patients will benefit from the

long-term use of opioids, and some patients express great fear of discontinuing those drugs.

Psychologists treating patients who are taking opioids for chronic conditions can monitor them for the common psychological side effects of opioid use: sleepiness, dizziness, confusion, and depression. The long-term use of opioids may induce depression in some patients who had no previous history of depression (Scherrer et al., 2017). The biochemical properties of the drug may cause depression, although physical inactivity or social isolation may contribute as well.

Most patients who take opioids for chronic conditions do not abuse them. But the risk of abusing opioids increases for patients who have a high perception of pain, negative affect, or pain catastrophizing (Martel et al., 2020). Habits of misusing opioids and other substances often go through periods of exacerbation and remission. Patients may have long periods of abstinence, although they risk abusing opioids again, especially if they experience unusual pressures or emotional strains (Schuckit, 2016).

If patients using opioids show signs of mental deterioration consistent with opioid misuse or begin to misuse prescription medication (hoarding pills, forging prescriptions, purchasing pills from illegal sources, etc.), then it would be appropriate for the treating psychologists to consider the presence of an opioid use disorder. In those cases, it would be indicated to have a frank discussion with patients about the possibility of specialized treatments.

Some interventions such as the SBIRT (screening, brief intervention, and treatment; for more information see SAMHSA, 2017) or motivational interviewing (see www.motivationalinterviewing.org) have had success in screening or motivating such patients. SBIRT is a protocol designed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify patients with substance abuse disorders and to refer them if necessary. SBIRT incorporates many of the elements of motivational interviewing.

Patients do not always represent their drug use accurately to their treating professionals. Many patients may feel shame at their behavior. They may have adopted

common negative stereotypes such as that persons who abuse drugs are morally weak. Or they may assume that the only treatments will be dehumanizing and unnecessarily confrontational. Both SBIRT and motivational interviewing try to reduce defensiveness by adopting a collaborative, nonjudgmental, and caring approach. Psychologists appreciate that their patients are the authorities on their own lives and respect their patients' experiences and interpretations of events. In motivating interviewing, for example, psychologists would not freely give their advice to their patients but would give it in response to direct questions from patients or would ask them permission to give their opinions.

Both approaches acknowledge the need for patience. Often patients are not willing to accept the possibility that they have an abuse disorder (according to the Stages of Change model, they would be in the precontemplative stage), but that does not mean that the interview was a failure, if the patients left feeling that they were treated respectfully and that their psychologist cared about them. It leaves the door open for future conversations. Evidence suggests that these interventions can be effective in reaching





their goals (Bray et al., 2017; Society of Clinical Psychology, n.d.).

OPIOID ABUSE TREATMENT OPTIONS

Relatively few psychologists have expertise in treating patients with substance use disorders. Consequently, most psychologists who identify patients with these disorders should refer them to specialists. At the risk of great oversimplification, treatment on substance use disorders could be divided into two approaches with differing philosophies. The traditional medical approach sees abstinence or medication-assisted control as the only pathway to recovery. The harm-reduction approach adopts a lower threshold for accepting patients into treatment and would consider working with patients on life changes even if, at this point, they were not ready for abstinence. Harm reduction strategies “support any steps in the right direction” and “the harm reduction practitioner seeks to meet with the client where he or she is in regard to motivation and ability to change” (Logan & Marlatt, 2010, p. 201).

Some patients who are abusing opioids may need detoxification services that require withdrawal under medical supervision. Withdrawal symptoms could include sweating, restlessness, increased pulse rate, joint pains, runny nose, upset stomach, tremors, goose bumps, and anxiety or irritability (Schuckit, 2016). Physicians may prescribe long-acting oral opioids such as methadone, extended-use

naltrexone, or buprenorphine to reduce the symptoms of withdrawal. Other medications may be prescribed to address specific withdrawal symptoms.

After withdrawal, many patients benefit from medications to treat their addiction. Physicians may maintain recovery by prescribing methadone, naltrexone, or buprenorphine, although the outcome with naltrexone has not been as positive as that with the other medications. Although these medications have opioids in them, they stabilize the physiological processes that were disrupted by the abuse of opioids (Volkow & McLellan, 2017). Some programs will keep patients on the methadone or buprenorphine for 1 year before weaning them off, although other programs will keep patients on them longer (sometimes

recommending lifelong participation in the programs). Good programs using medications include behavioral intervention to help ensure abstinence from opioids, such as self-help groups, patient education, or group or individual psychotherapy. Programs that do not include psychological supports or interventions risk high levels of patient attrition.

But patients often balk at these traditional treatment options. Some patients are not yet at the point that drugs interfere that much in their lives. Or they may fear that going off the opioids would mean that their chronic pain would only get worse. Others assume that the only treatment option is to stay in an expensive, highly regimented, and confrontational 28-day residential program. They worry that agreeing to treatment means a loss of control over the treatment decisions. Still other patients strongly resist the stigma of being an “addict,” and the shame associated with that label, including the implication that they are morally defective in some way. Some patients do not want to participate in 12-step programs because they or a relative may have had bad experiences with 12-step programs in the past.

Another approach to addiction focuses on harm reduction for patients who are not ready for abstinence, but who want to make some changes. Psychologists working from the harm-reduction model avoid the “take-it-or-leave-it” approach to treatment, and work to understand the concerns of the patients and encourage



them to consider their life goals and how to reach them. Using the strategies found in motivational interviewing, they may ask the patients to make minor, but significant, changes in their behavior. For example, they and the patient may agree that the patient will cut back on the number of opioids used in 1 day (or a week). Or they may discuss with the patient the importance of having Narcan (a medication used to quickly reverse opioid overdoses) available or the implications of opioid use on their driving.

FATAL OPIOID OVERDOSES AND SUICIDE

Drug overdoses are now the leading cause of accidental deaths within the United States. The number of drug overdoses in the United States has tripled since 1999 and, of the 70,630 drug overdoses in 2019, 71% involved opioids (Mattson et al., 2021). In about half of the opioid-related overdoses, stimulants were combined with opioids (O'Donnell et al., 2020). Opioid overdoses and the other types of deaths of despair (cirrhosis of the liver and suicides) have all been increasing noticeably within the United

States in recent years. A 1% increase in state-wide levels of depression was associated with a 26% increase in opioid-related deaths (Foley & Schwab-Reese, 2019).

It is often hard to distinguish between an accidental and intentional death, and many overdoses listed as accidental may have been intentional (Bogdanowicz et al., 2016). Furthermore, Connery et al. (2019) found that among those survived near fatal overdoses of fentanyl, 57% reported that they either strongly wanted to die or definitely wanted to die, and Gicquelais et al. (2020) reported that half of the persons with opioid overdoses had some suicide intent, including some with passive suicidal thoughts.

The risk of an accidental overdose increases if patients are receiving the maximum daily dose of opioids, have coexisting substance abuse problems, and were also taking benzodiazepines. Perhaps one-quarter of these overdoses are suicides. In addition, the number of nonfatal opioid overdoses requiring treatment in a hospital or emergency room has increased by a factor of six in the last 15 years (Knowlton et al., 2013). Nonfatal overdoses often cause brain or nerve damage (Madras, 2017).

The increase in drug overdoses varies geographically within the United States. States in the middle Appalachian region are especially hard hit. In 2020, Pennsylvania eighth among all states in the rate of drug overdose deaths while West Virginia was first and Ohio was fourth (CDC, 2021). The rate of fatal drug overdoses due to opioids in Pennsylvania increased fivefold from 2010 to 2018 (National Institute on Drug Abuse, 2020).

Opioids cause death by their effect on receptors in the brain stem that control breathing. Benzodiazepines are problematic because they also depress the functioning of the respiratory system. Street drugs are especially dangerous because the seller of the drug, either knowingly or unknowingly, may not always accurately represent the nature and strength of the drug. Consequently, a user might fatally overestimate the amount of drug necessary to achieve the desired physiological reaction.

First responders can administer naloxone to prevent many drug overdoses by preventing respiratory failure. A user-friendly intranasal version has been developed (Narcan Nasal Spray). However, someone






must administer the drug. In addition, naloxone may not be effective with very high doses of opioids or overdoses caused by fentanyl (Volkow & Collins, 2017).

Heroin users have a high rate of mortality either from overdoses or from a constitution weakened by the prolonged use of heroin. One longitudinal study found that Australians who habitually took heroin had an average age of death in their late 30s and an average life expectancy of 43.5. Overdoses accounted for half of the deaths including 13% that were suicides (Darke et al., 2016). Patients recently released from drug treatment centers have a pronounced risk of overdosing. Although they may have an intense desire to take the drug, they have lost the physical tolerance that once allowed them to take high doses of the drug (Volkow & McLellan, 2017).

Patients who are prescribed opioids have

an increased risk to die from suicide. More than one-fourth of patients being treated for opioid abuse disorders had a previous suicide attempt (Bogdanowicz et al., 2016). However, it is hard to separate the unique effects of opioid use from other risk factors such as the presence of uncontrolled pain (Campbell et al., 2016), or co-occurring substance use or mental health disorders. Nonetheless, Ashrafioun et al. (2017) found that opioid misuse was related to suicidal behavior even when overall health ratings, depression, anxiety, and the abuse of other substances was controlled, suggesting that opioid misuse has an impact on suicidal behavior independent of other coexisting predictors of suicide.

Health professionals can reduce overdoses by screening patients for suicidal ideation or for risk factors or warning signs for suicide, educating patients about the

problems associated with mixing opioids and other drugs, and ensuring good follow-up services for patients recently released from drug treatment facilities. On a public health level, it is good for first responders to have naloxone if they encounter an individual experiencing an overdose. A study within the VA hospital system showed that suicide rates by drug overdoses were lower in facilities that required more drug screens, provided more follow-up appointments after new prescriptions were written, and had lower rates of coprescribing sedatives, such as benzodiazepines (Im et al., 2014). 

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GLOSSARY

Buprenorphine: a medication used to treat opioid addiction. It is a partial agonist, which means it can produce some euphoria and respiratory suppression; its effects are less than those of full agonists such as heroin or methadone.

Chronic pain: "pain that persists beyond the time frame for resolution of the underlying condition" (Palermo & Kerns, 2020, p. 741).

Clinical inertia: failure to establish treatment goals and modify treatment to reach those goals.

Deaths of despair: deaths caused by cirrhosis of the liver, suicide, or drug overdoses, all of which are presumed to have an underlying element of despair among the decedents.

Drug poisoning (overdoses): "includes deaths resulting from unintentional or intentional overdose of a drug, being given the wrong drug, taking a drug in error, or taking a drug inadvertently" (Hedegaard et al., 2020, p. 5).

Gain framing: offering options to patients in terms of potential benefits.

Harm reduction: interventions for the misuse of alcohol

or other drugs designed to reduce the frequency of harmful behaviors without necessarily leading to abstinence.

Heroin: an illegally made opioid synthesized from morphine.

Methadone: a synthetic opioid.

Natural opioids: morphine.

Naloxone: "opioid specific antagonist that displaces heroin, fentanyl and most prescription opioids from the mu-opioid receptor within minutes of administration" (Yaster et al., 2020, p. 331).

Opioids: a class of drugs that interact with opioid receptors in the brain and other areas of the nervous system to produce pleasurable effects or to relieve pain.

Pain: "multidimensional, dynamic interaction among physiological, psychological, and social factors that reciprocally influence each other" (Edwards et al., 2016, p. T71).

Pain catastrophizing: "an exaggerated negative cognitive orientation toward pain involving magnification of the threat value of pain, helplessness in the

context of pain and difficulty inhibiting pain-related thoughts (Aaron et al., 2020, p. 800).

Psychostimulants with abuse potential: methamphetamine, amphetamine, or methylphenidate.

Semi-synthetic opioids: oxycodone, hydrocodone, hydromorphone, oxymorphone.

Synthetic opioids other than methadone: tramadol, fentanyl, or fentanyl analogs.

Suboxone: medication for opioid addictions that contains both buprenorphine and naloxone.

Tolerance: "the need for marked increased amount of opioid to achieve the desired effect or intoxication and/or a markedly diminished effect with continued use of the same amount of drug (Yaster et al., 2021, p. 330).

Withdrawal: psychological or physical symptoms such as nausea, diarrhea, insomnia, or high anxiety that can occur after the abrupt discontinuation of a drug that has created dependence.



THE MINDS, LIVES, AND MOTIVATIONS OF MASS ATTACKERS

This workshop is presented by a coalition of over 30 State, Provincial, and Territorial Psychological Associations

Peter Langman, PhD



Monday, January 27, 2023



2:00 - 5:00 p.m. EST



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This webinar will start with a review of the justifications cited by perpetrators of mass attacks, as well as a consideration of underlying psychological dynamics. Next, three psychological types of mass attackers will be presented to demonstrate the intersection of their internal dynamics and life experiences. Following this, four additional cases will be reviewed to highlight the variability in functioning among perpetrators and the need to look behind superficial accomplishments to detect risk factors for violence.

Course Objectives

At the conclusion of this course, participants will be able to:

1. Identify three psychological categories of mass attackers.
2. Explain the role of identity issues and aspirations in mass attackers.
3. Discuss the intersection of psychological dynamics and life experiences as risk factors for violence.

The articles selected for 1 CE credit in this issue of *The Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits of continuing education into the next renewal period.

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Learning objectives: This issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Introduction to Opioid Use and Misuse

1. Which of the following are TRUE?

- a. Deaths from overdoses tripled from 1999 to 2019.
- b. 11% of Americans misused a prescription for opioids in 2018.
- c. Long-term opioid use increases the risk of cardiovascular disorders.
- d. All the above

2. Deaths of despair could include all the following EXCEPT

- a. Suicides.
- b. Homicides.
- c. Opioid overdoses.
- d. Cirrhosis of the liver.

3. In colonial America, physicians prescribed opioids to control

- a. Diarrhea.
- b. Typhoid fever.
- c. Smallpox.
- d. All the above.

4. A person who has an opioid use disorder may prefer heroin because it

- a. Is less expensive and more accessible than other opioids.
- b. Prevents them from getting addicted to other drugs.
- c. Has none of the side effects found in other opiates.
- d. All the above.

5. Compared to prescription opioids, heroin is especially problematic because

- a. It may have contaminants.
- b. It can cause serious infections such as hepatitis C if injected.
- c. The strength of the drug might vary if purchased on the street.
- d. All the above.

6. Dr. Smith saw a patient who had been prescribed opioids by an emergency room physician the night before. Dr. Smith assumed that the ER physician knew what she was doing and did not conduct a thorough evaluation to determine the appropriateness of continuing the prescription and simply renewed it. This is an example of

- a. Learned helplessness.
- b. Clinical inertia.
- c. The fundamental attribution error.
- d. All the above.

7. The opioid epidemic started, in part, because many physicians did not have a good understanding of pain management and were too quick to believe the exaggerated safety claims of opioid drug manufacturers.

TRUE
FALSE

8. Mitigation strategies include

- a. Avoiding the prescription of sedatives and opioids for the same patient.
- b. Using nonopioid pain-reduction strategies instead of opioids.
- c. Monitoring patients who have been prescribed opioids.
- d. All the above.

9. Research on the use of opioids shows that

- a. Most patients prescribed opioids went on to abuse heroin.
- b. Depression sometimes occurs among patients with long-term prescriptions of opioids, even in the absence of a history of depression.
- c. New advances have made heroin use disorders a very easily treated disorder.
- d. Once patients have stopped abusing opioids, they never relapse.

10. Good behavioral interventions that can supplement the pharmacological treatment of opioid use disorders include

- a. Patient education.
- b. Self-help groups.
- c. Individual or group psychotherapy.
- d. All the above.

11. Methadone treatment helps many patients with an opioid use disorder.

TRUE
FALSE

12. It is especially dangerous to mix benzodiazepines and opioids because benzodiazepines

- a. Are “uppers” while opioids are “downers.”
- b. Frequently cause psychotic reactions.
- c. Like opioids, tend to depress the functioning of the respiratory system, thus increasing the risk of a respiratory system shut down and death.
- d. All the above.

13. The author states that patients who were recently released from an inpatient or residential drug treatment center have an increased risk of dying from a drug overdose because

- a. Their bodies have lost the physical tolerance to high doses of drugs.
- b. They have severe depression after leaving their friends in the facility.
- c. The contacts they made in the facility make it easier for them to get illegal drugs.
- d. All the above.

14. The emergency administration of naloxone may NOT always be effective in preventing an overdose from fentanyl or other extremely powerful opioid substances.

TRUE
FALSE

15. Ashrafioun et al. found that opioid misuse was

- a. Unrelated to suicidal behavior.
- b. Related to suicidal behavior because of the psychotic reactions that opioid abusers always experienced.
- c. Related to suicidal behavior even when self-reported health, anxiety, and depression were held constant.
- d. None of the above.



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CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, November 2022

Please circle the letter corresponding to the correct answer for each question.

- | | | | |
|------------|------------|-------------|-------------|
| 1. a b c d | 5. a b c d | 9. a b c d | 13. a b c d |
| 2. a b c d | 6. a b c d | 10. a b c d | 14. T F |
| 3. a b c d | 7. T F | 11. T F | 15. a b c d |
| 4. a b c d | 8. a b c d | 12. a b c d | |

Satisfaction Rating

Overall, I found this issue of *The Pennsylvania Psychologist*:

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

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Calendar

Friday, January 27, 2023

The Minds, Lives, and Motivations of Mass Attackers
Webinar
2:00 - 5:00 pm

Friday, January 27 - Sunday, January 29, 2023

Wellness Weekend
Inn at Leola Village
Leola, PA

Thursday and Friday, March 30-31, 2023

PPA's VIRTUAL Spring Conference

Wednesday, June 21 - Saturday, June 24, 2023

PPA2023 Convention
In-person at The Penn Stater Hotel & Conference Center
State College, PA

Thursday and Friday, October 5-6, 2023

PPA's VIRTUAL Fall Conference 2023

November 30, 2023

License Renewal Deadline for Psychologists in Pennsylvania

Wednesday, June 12 - Saturday, June 15, 2024

PPA2024 Convention
Lancaster Marriott at Penn Square
Lancaster, PA

Home Study CE Courses

Act 74 CE Programs

Essential Competencies when Working with Suicidal Patients—1 CE

Four Ways to Enhance Your Suicide Assessments (Webinar)—1 CE

Talking about Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE

The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE

The Essentials of Managing Suicidal Patients: 2020—1 CE

The Essentials of Screening and Assessing for Suicide among Adolescents—1 CE

The Essentials of Screening and Assessing for Suicide among Adults—1 CE

The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE

The Essentials of Treating Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

General

*Ethical Issues with COVID-19 (Webinar)**—1 CE

*Ethical Responses when Dealing with Prejudiced Patients (Webinar)**—1 CE

*Ethics and Self-Reflection**—3 CE

*Foundations of Ethical Practice: Update 2019**—3 CE

Integrating Diversity in Training, Supervision, and Practice (Podcast)—1 CE

Interdisciplinary Collaboration in Assessing Capacity in the Elderly (Webinar)—1 CE

Introduction to Working with Chronic Health Conditions—3 CE

*Legal and Ethical Issues with High Conflict Families**—3 CE

Mental Health Access in Pennsylvania: Examining Capacity (Webinar)—1 CE

*Record Keeping for Psychologists in Pennsylvania**—3 CE

Telepsychology Q&A (Webinar)—1 CE

Why the World is on Fire: Historical and Ongoing Oppression of Black African American People in the United States (Webinar)—1.5 CE

***This program qualifies for contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

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