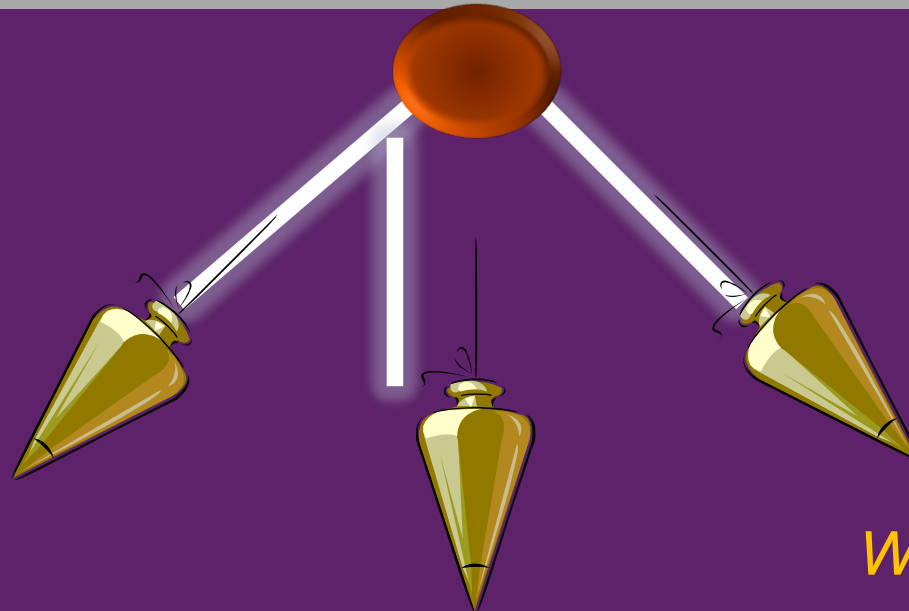


The Chemical Coper

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The Opioid Pendulum



Avoidance

Even dying people
at risk of addiction

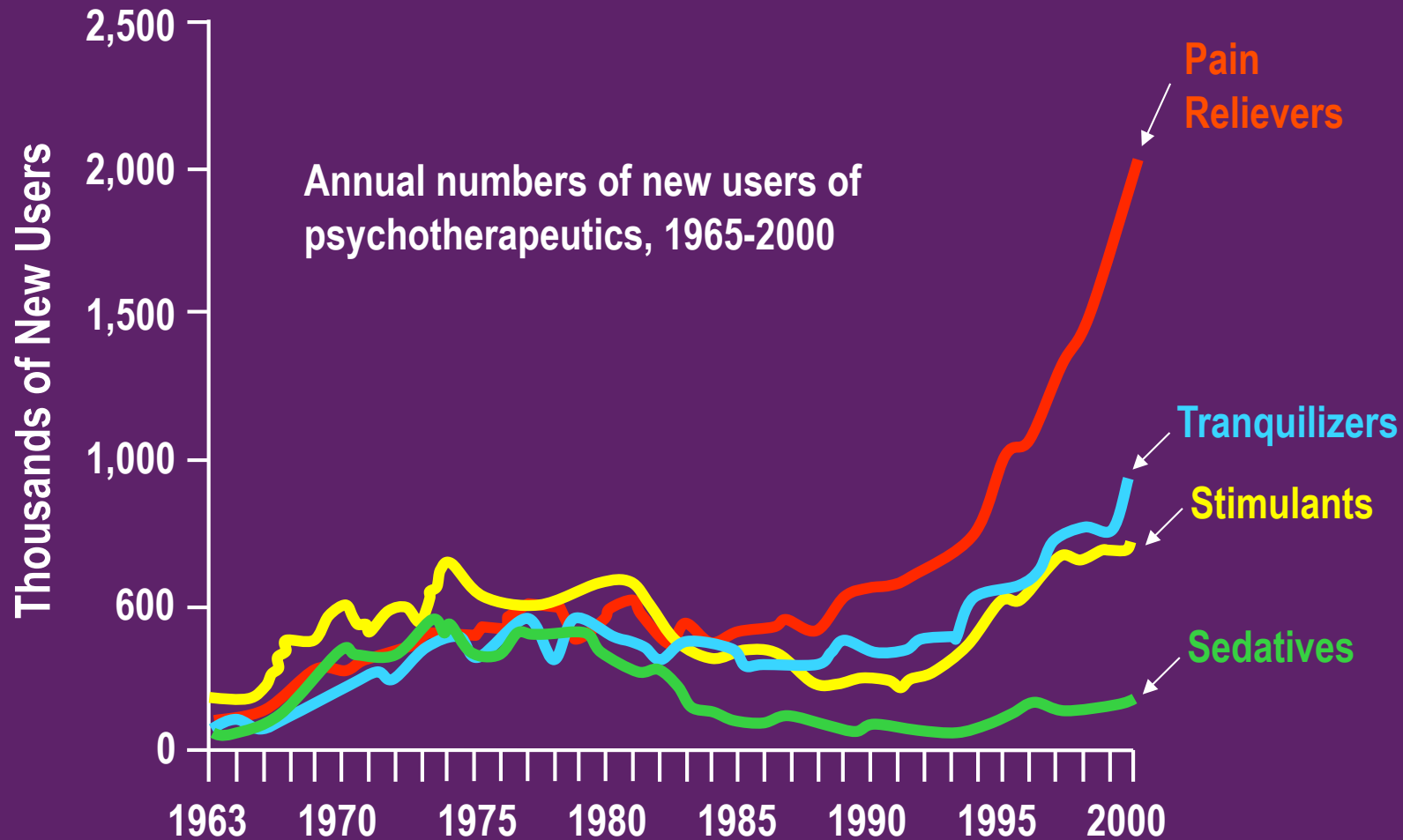
Balance

Risk stratification and
principles of addiction
medicine applied to
opioid prescribing
regardless of the pain
problem at hand

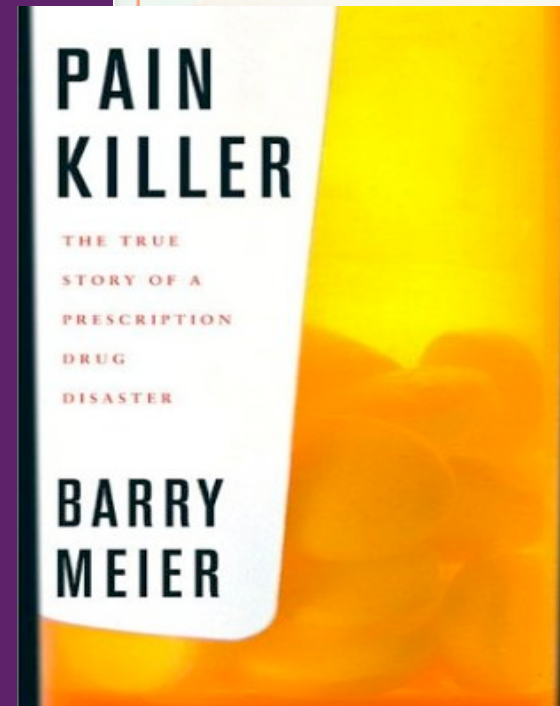
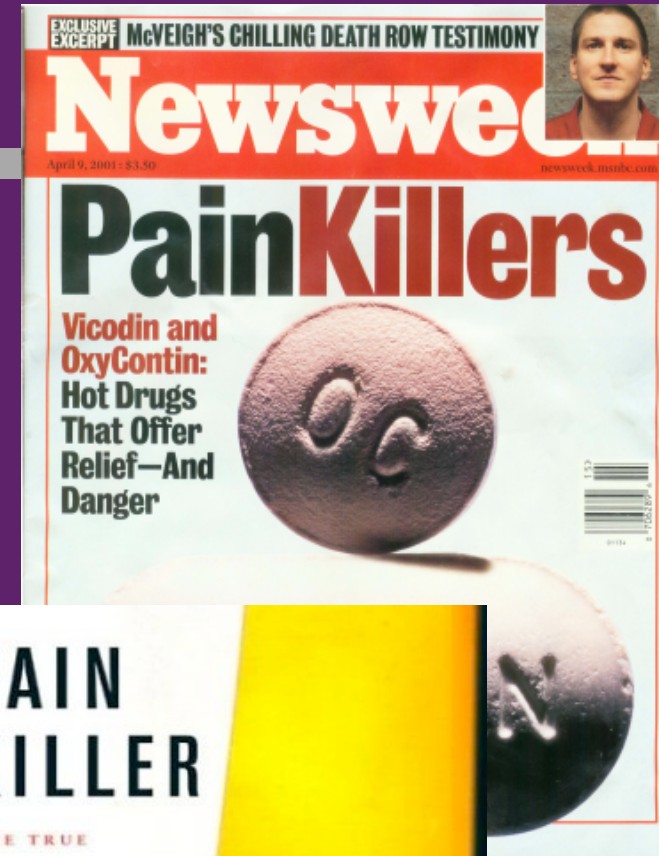
Widespread Use

Opiophobia must go

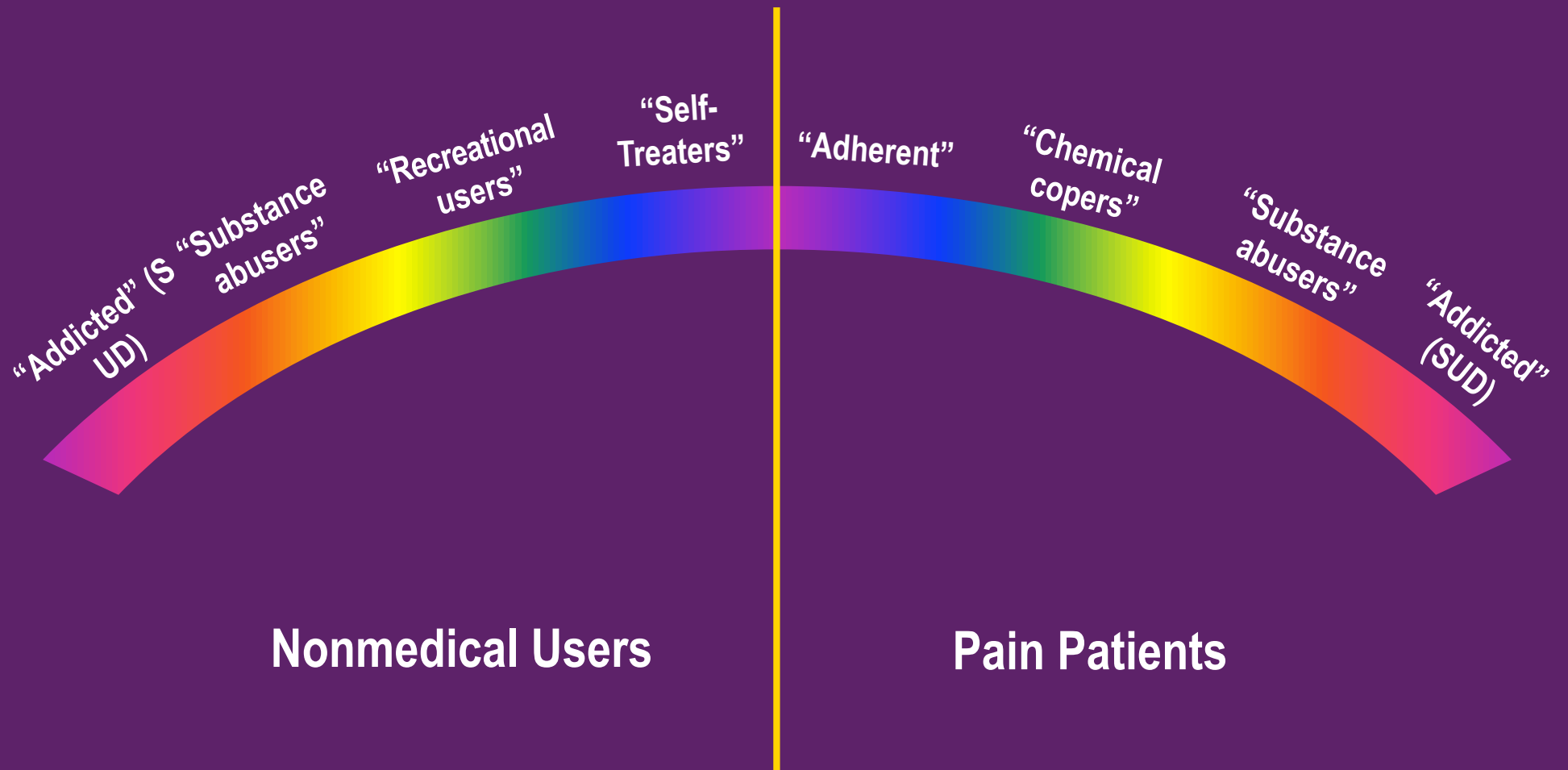
Use of Psychotherapeutic Agents



The OxyContin Story



Population of Rx Opioid Users Is Heterogeneous



The Chemical Coper

- Probably outnumber frankly addicted patients by 3 to 1 in pain practices
- Are unsettling to clinicians as they are seen as patients that are floundering on a controversial therapy
- Tendency to dabble in abuse never rises to level of compulsiveness or out of control that might land them an addiction referral

The Chemical Coper

- Term first coined by Bruera and colleagues in the palliative care setting
 - Often patients with history of alcohol or substance abuse
 - Had tendency to somatize end of life related stress and distress
 - Felt globally bad
 - Received unusually high number of centrally acting meds
 - Tendency to become delirious secondary to over-medication
- Khantzian has referred to substance abusers as
 - Engaging in self medication
 - Having de-differentiated affective arrays

The Chemical Coper

- Key clinical features
 - Alexythymic
 - Somatizing
 - Overly drug focused
 - Unmotivated for non-drug therapies
 - Make little progress towards psychosocial goals

The Chemical Coper

- Bears resemblance to addiction with regard to the “centrality” of the drug and drug procurement to the patient
- CCs need structure, psych input, and drug treatments that ***decentralize*** the pain medicine to their coping
- Decentralize pain medication: reduce its meaning, undo conditioning, undo socialization – accomplished through pain-related psychotherapy and prudent drug selection

Chemical Coping Inventory

- 14 item measure reduced from 38 items
- One general factor
 - Items written initially to cover
 - Alexythymia
 - Drug centrality
 - Failure to meet psychosocial goals
 - Thrill seeking
 - Rejection of non-drug treatments

The Four “A’s” of Pain Treatment Outcomes

- ❑ **A**nalgesia (pain relief)
- ❑ **A**ctivities of Daily Living (psychosocial functioning)
- ❑ **A**dverse effects (side effects)
- ❑ **A**berrant drug-taking (addiction-related outcomes)

My Chemically Coping Dog on Opioids



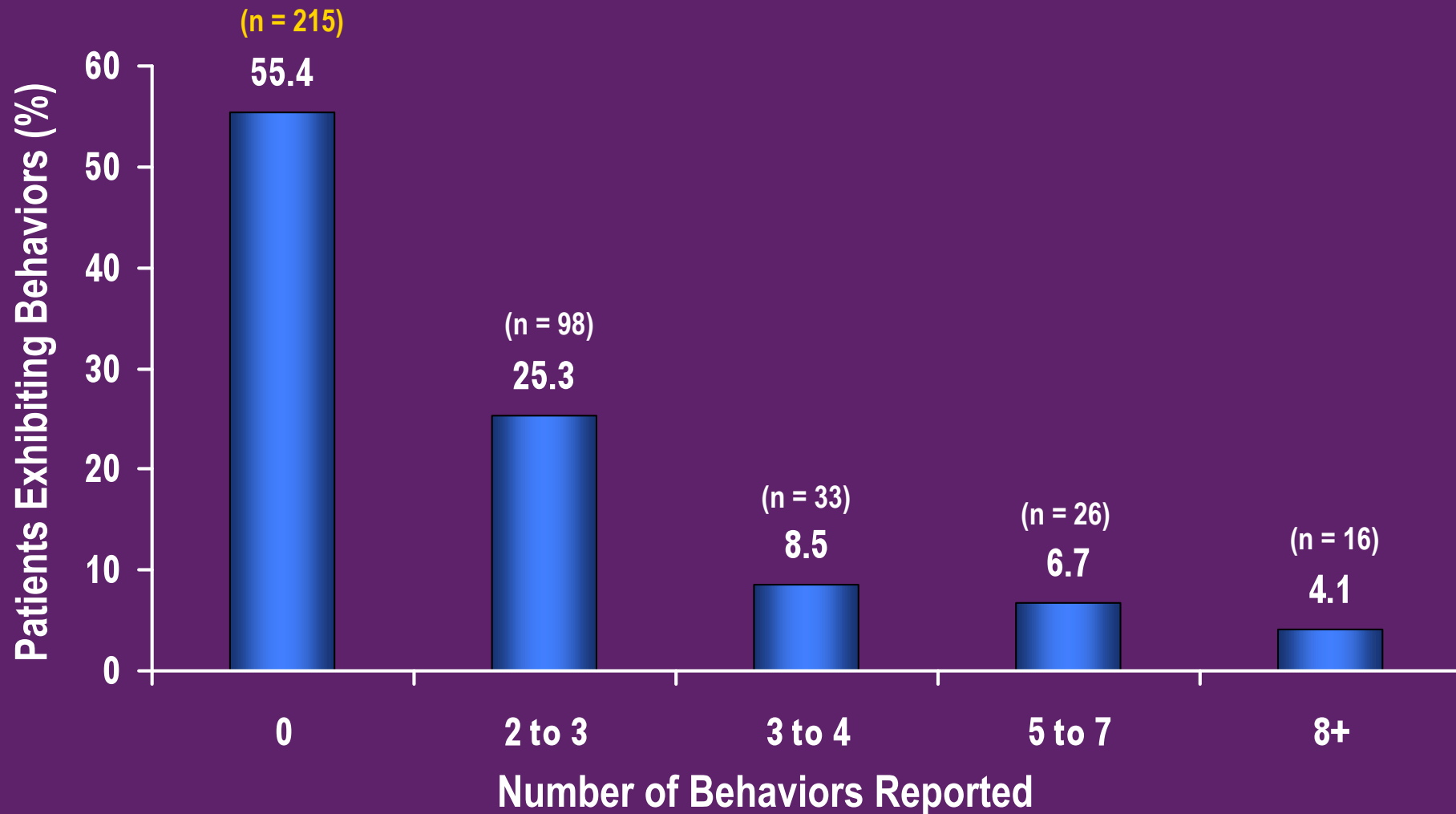
Aberrant Drug-taking Behaviors: The Model

- Probably more predictive
 - Selling prescription drugs
 - Prescription forgery
 - Stealing or borrowing another patient's drugs
 - Injecting oral formulation
 - Obtaining prescription drugs from non-medical sources
 - Concurrent abuse of related illicit drugs
 - Multiple unsanctioned dose escalations
 - Recurrent prescription losses
- Probably less predictive
 - Aggressive complaining about need for higher doses
 - Drug hoarding during periods of reduced symptoms
 - Requesting specific drugs
 - Acquisition of similar drugs from other medical sources
 - Unsanctioned dose escalation 1–2 times
 - Unapproved use of the drug to treat another symptom
 - Reporting psychic effects not intended by the clinician

Differential Diagnosis: Aberrant Drug-Taking Attitudes & Behavior

- ❑ Addiction
 - *Compton*
 - *Fleming*
- ❑ Pseudo-addiction
 - *Elander*
- ❑ Other psychiatric diagnosis
 - Organic mental syndrome
 - Personality disorder
 - Chemical coping
 - Depression/anxiety/situational stressors
 - *Butler*
- ❑ Criminal intent
 - *Katz*
 - *Jung & Reidenberg*

Aberrant Behaviors (n = 388) (Passik, Kirsh et al, 2005)



Opioid Risk Tool (ORT)

Mark each box that applies:

		Female	Male
1. Family history of substance abuse			
Alcohol	1	<input type="checkbox"/>	<input type="checkbox"/>
Illegal drugs		<input type="checkbox"/>	2 <input type="checkbox"/>
Prescription drugs	4	<input type="checkbox"/>	<input type="checkbox"/>
2. Personal history of substance abuse			
Alcohol	3	<input type="checkbox"/>	<input type="checkbox"/>
Illegal drugs		<input type="checkbox"/>	4 <input type="checkbox"/>
Prescription drugs	5	<input type="checkbox"/>	<input type="checkbox"/>
3. Age (mark box if between 16-45 years)		<input type="checkbox"/>	1 <input type="checkbox"/>
5. History of preadolescent sexual abuse		<input type="checkbox"/>	3 <input type="checkbox"/>
6. Psychological disease			
ADO, OCD, bipolar, schizophrenia		<input type="checkbox"/>	2 <input type="checkbox"/>
Depression		<input type="checkbox"/>	1 <input type="checkbox"/>
Scoring totals:		_____	_____

Administration

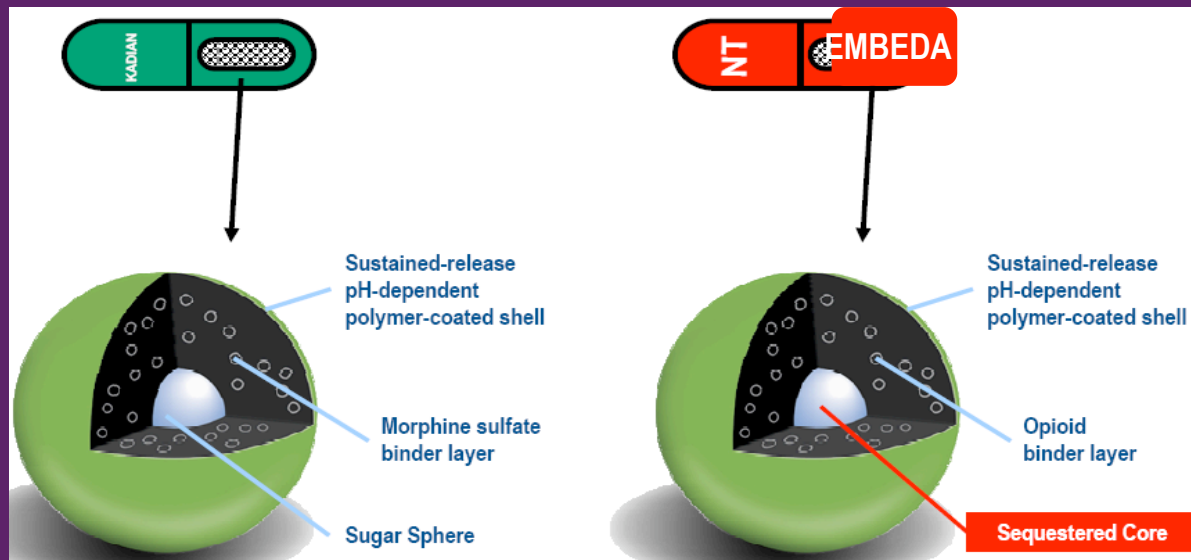
- On initial visit
- Prior to opioid therapy

Scoring

- 0-3: low risk (6%)
- 4-7: moderate risk (28%)
- ≥ 8: high risk (> 90%)

EMBEDA™: Pivotal Trial

- Phase III double-blind, randomized, placebo-controlled, 12-wk, multicenter trial
 - >500 OA (hip/knee) pts moderate-severe pain
 - Primary endpoint: significant pain relief ($P < .05$)
- NDA filed February 2008



Alpha Pharma Press
Releases. Oct 15, 2007;
Nov 29, 2007; Feb 28,
2008.
ClinicalTrials.gov:
NCT00420992.

Opioid Renewal Clinic

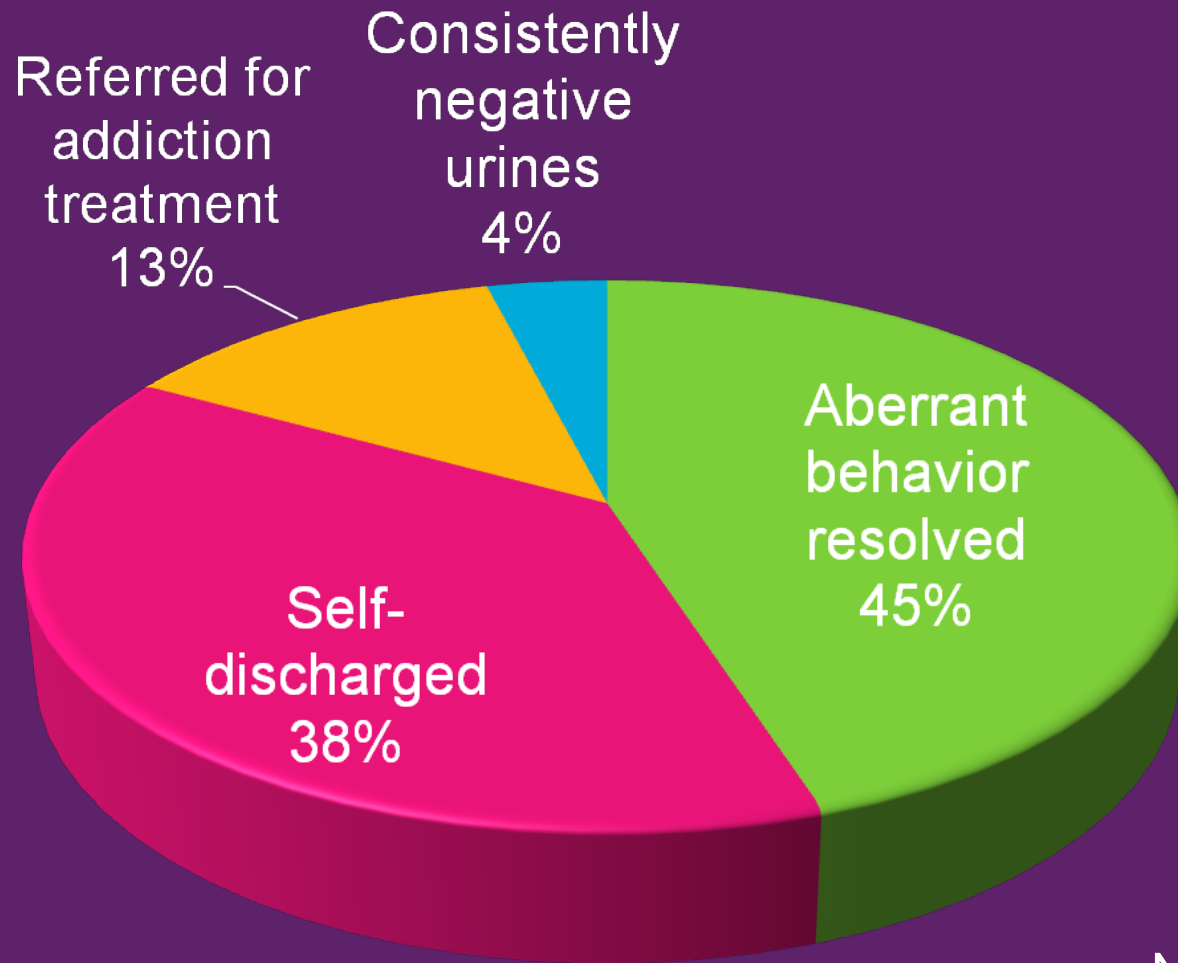
Procedure

- Consult from PCP
- Eligibility
 - Workup & pain dx
 - Opioid Treatment Agreement
 - Baseline urine drug test
- PCP CONTINUES TO BE RESPONSIBLE TO PRESCRIBE OPIOIDS

Strategy

- Opioid Treatment Agreement
 - Second Chance Agreement
- Frequent visits
- Prescribing opioids on short-term basis
 - ie, weekly or bi-weekly
- Random UDT
- Pill counts
- Co-management with addiction services

Aberrant-Behavior Categories (n=171)



Aberrant behavior = 171
No aberrant behavior = 164

Tailoring The Approach

- The uncomplicated patient: Minimally Monitored Drug Only Pain Therapy
- The patient with co-morbid psychiatric and coping difficulties: “Chemical Copers”
- Addicted patients:
 - The actively abusing
 - The patient in drug free recovery
 - The patient on methadone maintenance

Minimally Monitored Drug Only Pain Therapy

- Minimal structure required due to lack of co-morbid psychiatric or substance abuse problems, and lack of contact with addiction subculture
- Managed via optimization of opioids and side effect management – ie, routine medical management
- 30 day supplies of meds with liberal rescues, monthly follow-up

Outpatient Management of the Chemically Dependent Pain Patient

- Maximally structured approach includes:
 - Frequent visits
 - Limited supply of meds
 - Managed primarily with long-acting opioids with low street value – judicious use of rescues
 - Urine Toxicology
 - Recovery program/psychotherapy

The Middle Ground

- Use of sustained release opioids only
- Rehabilitative and psychosocial approaches
- Emphasis on wellness and need for behavioral change
- Psychotherapy for:
 - Motivational issues and goal setting
 - Adherence monitoring
 - Stress management and affect labeling

Motivational Issues

- Often nihilistic about anything that doesn't directly improve pain
- Pain physicians often are not trained in motivational interviewing and techniques
- Often motivation is done via strong-arming
 - Vs. leading by example
 - Vs. breaking down behavioral barriers
 - Vs. using cognitive techniques

Conclusion

- CCs are difficult patients to treat
- Unique approaches need to be taken to motivate and structure therapy
- Sustained release opioids should be cornerstone of drug therapy if opioids to be used