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Coexisting Addiction and Pain in People Receiving Methadone for Addiction

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Abstract

The aim of this qualitative study was to examine the narratives of people who experience chronic pain (lasting 6 months or more) and were receiving methadone for the treatment of their opiate addiction through a major methadone clinic. This paper featured the pathway of how the participants developed chronic pain and addiction, and their beliefs of how prescription opioids would impact their addiction in the future. Thirty-four participants who experienced chronic pain and received methadone for treatment of opiate addiction were willing to tell the story of their experiences. The findings in three areas are presented: (a) whether participants experienced addiction first or pain first and how their exposures to addictive substances influenced their experiences, (b) the significance of recreational drug use and patterns of abuse behaviors leading to chronic pain, and (c) participants' experiences and beliefs about the potential for abuse of prescription opioid used for treatment of pain.

Keywords

illicit/illegal pharmaceuticals; health behavior/symptom focus; pain; therapeutic medications; community; location of care; qualitative; methods; adults; population focus

The rates of two problems, chronic pain and addiction are on the rise in the United States, each being tracked separately for chronic pain and for addiction. Chronic pain impacts 116 million adults in the United States (Institute of Medicine [IOM], 2011). Nearly half of those chronic pain sufferers receive no pain treatment (American Pain Foundation, 2008). Approximately 4.5 million Americans reported the use of prescription pain relievers for non-medical reasons that were not prescribed to them (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). In 2011, 2.3 million people used psychotherapeutic drugs nonmedically for the first time within the past year creating an average of 6,400 new initiates per day (SAMHSA, 2012). A report by SAMHSA (2012), revealed that during 2010 and 2011 over half of the nonmedical users of psychotherapeutic drugs obtained their prescription drugs from a family member or friend for free. To further

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understand this growing problem, this study reveals the experiences of those with coexisting addiction and pain.

The Knowledge Deficit When Addiction and Chronic Pain Coexist

Insufficient understanding of the problem of chronic pain has led to substandard treatments by health care providers who serve these patients (IOM, 2011). The literature contains studies on the experiences of people with chronic pain who are receiving opioids for the treatment of pain without symptoms of addiction (Arnaert & Ciccotosto, 2006; Blake, Ruel, Seamark, & Seamark, 2007; Vallerand & Nowak, 2009; Watson, 2012). There are studies of those with chronic pain and substance use disorder or who developed iatrogenic addiction from the treatment of pain (Morasco & Dobscha, 2008; Rhodin, Gronbladh, Nilsson, & Gordh, 2006; Rosenblum et al., 2008; Trafton, Oliva, Horst, Minkel, & Humphreys, 2004; Wasan, Correll, Kissin, O'Shea, & Jamison, 2006). Nevertheless, there is a gap in the literature to help us understand the person who lives with the interface of addiction and pain, and the path they take to get there.

The experiences of those living with chronic pain and receiving opioids for pain without symptoms of addiction had been explored through qualitative methods, including phenomenology (Blake et al., 2007; Vallerand & Nowak, 2009), and case study reports of 17 patients (Watson, 2012). The populations studied included men and women ranging in age from 23 to 84 years, who had chronic pain and received opioids in outpatient pain practices, and in primary care clinics (Arnaert & Ciccotosto, 2006; Blake et al., 2007; Vallerand & Nowak, 2009; Watson, 2012). These studies showed that before patients received opioids for chronic pain, they were unable to function and perform their usual activities of daily living, and some had thoughts of suicide, but all were negatively impacted from their chronic pain (Arnaert & Ciccotosto, 2006; Blake et al., 2007; Vallerand & Nowak, 2009; Watson, 2012). After the opioids were started and stabilized in their dosing, their lives improved. Their opioid therapy was viewed as crucial to resuming normal function and engaging in daily activities such as cooking, housework, gardening, and visiting friends and family. Even so, they lived with the stigma of taking opioid therapy. Some were reluctant to disclose their use of opioids for treatment of pain, and others feared losing the analgesic regimens.

When patients with addiction were hospitalized and needed relief from their pain, a qualitative study using grounded theory (Morgan, 2006) revealed that patients felt the health care team did not know how to treat their pain and they experienced undertreatment of pain. In another qualitative study, some participants had a desire to rid themselves of pain with opioids, created a reactivation of their former addiction to alcohol or marijuana, and expanded their use to include prescription opioids (Sorajjakool, Aveling, Thompson, & Earl, 2006). These qualitative studies illustrate the problem of managing pain for those with a coexisting addiction.

There were quantitative studies suggesting that long-term opioid therapy for chronic pain led to iatrogenic addiction (Rosenblum et al., 2008; Vroman, Warner, & Chamberlain, 2009; Wasan, Correll, Kissin, O'Shea, & Jamison, 2006). In two methadone clinic studies, half of

patients reported pain as the reason for first using drugs (Jamison, Kauffman, & Katz, 2000; Rosenblum et al., 2008). Another study conducted at a methadone clinic reported that 31.7% of individuals stated their addiction preceded their chronic pain (Rhodin et al., 2006). When pain was intolerable, patients used two or more pharmaceutical preparations or supplemented prescriptions with alcohol or cannabis (Kouyanou, Pither, & Wessely, 1997). Furthermore, primary care patients in a Veterans Administration clinic with a lifetime history of substance use disorder were 3 to 6 times more likely to have aberrant medication-related behaviors than those without a history of substance use disorder (Morasco & Dobscha, 2008).

The conditions of coexisting addiction and chronic pain create complications above and beyond the problems pain and addiction created separately. For example, compared with those with pain or addiction alone, patients who experienced coexisting addiction and pain reported more psychiatric disturbances (Edlund, Steffick, Hudson, Harris, & Sullivan, 2007; Jamison et al., 2000; Morasco & Dobscha, 2008; Rosenblum et al., 2008), higher utilization of health care services for psychiatric and medical problems (Trafton et al., 2004), lower quality of life (Rhodin et al., 2006; Trafton et al., 2004), and less social support (Jamison et al., 2000). They also reported escalating symptoms of anxiety, depression, and drug-seeking behaviors compounded by their desperation in dealing with pain. When addiction intensified and pain was present, the level of a patient's desperation rose and their quality of life went down (Jamison et al., 2000).

Despite the prevalence and the problems associated with addiction and pain in our society, little is known about the individual variability, the experiences, and how they evolve. This study explored the problems associated with coexisting addiction and pain from the perspective of the individual. Understanding the problem from the standpoint of the patient with coexisting pain and addiction can help the health care professional to improve the quality of care.

Purpose

The purpose of this qualitative study was to examine the narratives of people who experience chronic pain and who were receiving methadone for the treatment of opiate addiction through a methadone clinic. The aim of the broader study was to address the kinds of experiences individuals have related to living with coexisting addiction and pain. Addressed in this paper are the structures and pathways of how the individuals developed the two conditions of addiction and chronic pain. In addition, the perceptions of future challenges the participants had regarding prescription opioids surfaced. The gaps in the literature pertain to the examination of the evolution of experiences and challenges of individuals who experience coexisting addiction and chronic pain. This study reveals the patients' experiences and perspectives and can aid in developing better therapies and outcomes.

Method

This qualitative study involved 34 participants living with coexisting addiction and chronic pain while receiving methadone for the treatment of their opiate addiction. Narrative inquiry was used because the design explored how people make sense of events, and helped answer the question, “What is going on here?” (Morse & Richards, 2002, p. 39; Riley & Hawe, 2005). The narratives were examined from data collected through semi-structured interviews to see how they made sense of events related to living with addiction and pain. The interview data were analyzed noting addiction occurring first or pain occurring first, relevant patterns, themes, similarities, differences, and how these related to the experiences of living with coexisting addiction and pain, while seeking help to manage these conditions.

Sample and Setting

Institutional Review Boards (IRB) from two institutions approved the study and all participants gave written informed consent. Purposive sampling was used to recruit individuals with chronic pain for 90-min interviews from a large Midwest metropolitan methadone center. Recruitment of participants occurred until no new data was revealed (Kuzel, 1999). Sampling represented both genders and captured race and ethnicity representative of the methadone clinic population. To be eligible to participate, participants had to be (a) at least 18 years, (b) conversant in English, (c) experienced pain for most of the time for 6 months or greater, (d) currently receiving methadone for opiate addiction, (e) able to get to and from the interview location without assistance, (f) willing to tell the story of their experiences with pain and addiction, and (g) not treated by the researcher for pain in the past 12 months, and would not be placed in the care of the researcher within 12 months following the study.

Data Collection

Three methods of data collection were employed including a demographic questionnaire, participant observation, and semi-structured interview. The demographic questionnaire had questions pertaining to age, gender, occupation status, race, ethnicity, relationship status, education level, self-reported pain diagnosis and pain treatments, family history of pain problems, drugs of abuse and duration and types of treatments, lifetime use of drugs of abuse, length of sobriety, and family history of addiction. The field notes were taken by the researcher, recording the participants nonverbal cues, tonal inflections, and ability to focus during the interview.

A semi-structured interview consisted of open-ended questions about their experiences relating to living with coexisting opiate addiction and chronic pain. Question topics were derived from the researcher’s clinical experiences as well as a review of the literature. The interviews were audio-taped and conducted in a private room adjacent to the methadone clinic and each lasted approximately 90 min. The interview guide is available from the author upon request. Participants were asked to discuss their lives with addiction and also with chronic pain and were asked about the connection between the two. In addition, they were asked what came first, their addiction or their pain, and what their experiences were when either was out of control, including their best ways to get pain relief. Audio-recordings

from the interviews were recorded on a digital file and sent to a transcription service via a secured link.

Data Analysis

Two analytical strategies were used: thematic and structural analyses. The interview transcript and field notes were read and comments were made in the margins of the narrative text on overall impressions and points of interest (Mayan, 2001). Themes were identified by the underlying patterns of experiences found in the interviews. A coding grid was then created and used for analysis. Structural analysis was used to place the experiences in the social context of the individual and to assist in analyzing the way the story was told (Labov & Waletzky, 1967; Riessman, 2008). See Table 1 for steps in data analysis. Narrative summaries were written for each participant and trajectories of their experiences were designed based on the narratives. The interview and transcripts were used for the examination of choice of vocabulary, vocal intonation, and body posture and movements. Searches were made for similarities and differences among participants' interpretations of the events in their lives. Further comparisons were made of the stories told by subgroups of the sample that differed by ethnicity/race, age, socioeconomic circumstances, gender, education, and work status to see how these factors may have affected their experiences. Exemplar narratives were found to best illuminate the analytic findings. Combining thematic analysis and structural analysis allowed for comparisons within the interview and also across cases (Riessman, 2008).

Rigor of the study was measured through two factors: credibility and dependability. Credibility was achieved by the extensive review by the dissertation committee members who were content and method experts. Dependability was assured when there was a stability of the participants' themes over time and a number of similar responses within a single time frame (Hall & Stevens, 1991).

Results

The participants with addiction and chronic pain consisted of 59% male and 41% female, mean age was 45 years (range = 22 to 63), 50% identified as African American and 35% identified as Caucasian, 88% were unemployed, 65% were either single or divorced, and 76.5% had a high school or college degree. Chronic pain diagnoses included low back pain; pain related to injuries such as crushing injury, gunshot wounds, fractured neck, fractured feet or plantar fasciitis; rheumatologic disorders including rheumatoid arthritis, osteoarthritis, fibromyalgia, myofascial pain; interstitial cystitis and endometriosis; wrist pain from carpal tunnel syndrome; and pancreatitis. The substances of abuse included heroin, cocaine, marijuana, alcohol, and prescription opioids and benzodiazepines. Themes from their narratives follow.

Addiction Preceded Pain

Recreational use and patterns of substance abuse signified an increased risk for prescription drug abuse. Of the total participants, 73% experienced addiction preceding their pain. This group was initially exposed to substances of abuse by their friends or family and progressed

to abuse of either illicit drugs alone or illicit drugs with prescription opioids. For most of the participants their subsequent pain problem was caused by injuries or illnesses related to their substance abuse pattern. Most of the participants who experienced addiction preceding pain stated their initial exposure to substances of abuse was through friends (96%, $n = 25$). They were exposed by friends in various venues such as parties, in a pool hall atmosphere, hanging out at someone's house or apartment or on the street, before school, after school, after work, or in the locker room following sports activities. One female participant related,

I was like 21. I didn't know what I was doing. I did it because everybody else was doing it, you know. I seen one girl she's nodding, "let me try that" and she gave it to me. I tried it and I liked it, thought I was cool.

Many individuals stated their drug use was motivated by a need to escape reality and their social situation. In their narratives, participants often stated drugs numbed their emotional pain. One female participant who was introduced to heroin by her boyfriend stated, "I knew that I could take it [heroin] to escape whatever problem I was experiencing at the moment." Initial exposure to illicit substances by friends led to one pathway of use that they felt was entertaining, provided a means of escape, and validated the context of addiction before pain became a problem.

Furthermore, participants who identified addiction preceding pain started using substances of abuse without any intention of becoming addicted and living the life of addiction. One male participant summarized, "Nobody wants to grow up to be a drug addict." Prescription opioids were received by 44% ($n = 11$) when their health care provider treated their pain from injuries, illness, or surgeries. This became significant because these participants were already abusing illicit substances. When the prescription opioids were added to treat pain, prescription opioids became drugs of abuse as well. When the participants took more than the prescribed dose, needed more for the treatment of pain, or were tapered off by the prescriber, they would usually illegally obtain more opiates from nonprescriptive venues. One participant stated,

By me taking all the medicine in the hospital, when I got out I couldn't get enough medicine to keep the pain away. I called a buddy of mine. I said, "I'm in pain." He said, "I'll be over there." And he brought me some Oxycontin 80. I chew one of them and save the other one and he gave me two Percocets so I chewed that. It killed the pain.

Whether the participants chose to abuse illicit drugs only or abuse illicit drugs and prescription opioids, their lifestyles while living with addiction and pain and obtaining the substances of abuse illegally were very stressful. This stressful life is reflected in the following account by a male participant:

One hundred dollars a day turned into \$500 a day habit, you know, and so I had to get out and do what I had to do. If I had to go stick somebody up, you know, just to get it that's what I did. Well my rap sheet is, you know, from stealing to possession, from possession to delivery, from deliveries to car theft, you know, anything to make a buck, just to get high. So after that I got sent to the penitentiary for a year.

The chaotic cycle of use, abuse, reckless behavior, violence, and physical harm characterized their lifestyle even when they experienced pain. This narrator talked about his lifestyle as an addict and a dealer, with a US\$500-a-day drug habit, and turning to crime to support his drug habit. He then developed back pain and used heroin and other illegal drugs to get rid of the pain. In the following narrative he revealed his perception of addiction and pain:

Pain and addiction, it's like you're on a war path, you know, because pain you just use more drugs whatever kind of drugs you use to ease the pain, you know, to make that pain go away, you know, you want more, you want more, you want more to where you know you're thinking it's like a psychological thing, you know, you think "if I smoke an eight ball that's gonna take the pain away from my back.

Drug use and pain management were intertwined because substance abuse led to their chronic pain and their chronic pain was treated with the drugs they used. Of the 25 participants who experienced addiction first, 88% experienced pain related to the substance abuse pattern or recreational use. When injuries or illnesses occurred some participants did not seek out health care and would cover up their pain with their substance abuse. Some participants did not even know they had pain or injuries while they were using drugs. They had fractures or ligament tears that would mend on their own and chronic pain would subsequently develop. One female participant injured her knee while using heroin, but every time she experienced pain, she thought it was from withdrawal and she would continue to use. She did not know, until she got off heroin, that she had torn a meniscus. She had it surgically repaired and now has chronic pain in her knee.

Pain Preceded Addiction

Approximately one quarter (26%, $n = 9$) of the total participants experienced pain in their lives before addiction. In this subgroup, the participants were initially exposed to opioids by their health care providers for the treatment of pain. About half of this subgroup of participants did not use illicit drugs recreationally before their pain, yet found themselves abusing prescription opioids and eventually illicit substances. Half of this subgroup recreationally used illicit substances, and they also abused their prescription opioids and illicit substances. The phrase *recreational use* was used by a small group of participants and needed further clarification.

Participants who self-identified as being recreational users were all male and reported occasionally using marijuana, alcohol, and cocaine. While they were recreational users, they felt in control of their transient use and did not consider themselves addicted to these substances because they could stop at any time. During their recreational use, four out of six participants had pain related to injuries that occurred during their recreational use. With repeated exposures to prescription opioids for the treatment of their pain, these individuals felt their addiction became out of control with these medications.

The total participants who had pain preceding their addiction were all initially prescribed opioids to treat their painful conditions and their use of prescription opioids became

uncontrollable. They abused their prescription opioids and eventually illicit substances. This was reflected in the following narrative as told by a self-identified former recreational user:

The doctor started giving me pills, and you know, my leg, I was still in pain. It was like a double-edged sword, you know, and then from there I started using heroin, to help me with my pain. And that really helped in the beginning. I would feel no pain for the whole day sometimes. I wound up getting hooked and it took me from living in a house to living on the street. It just destroyed my life. I didn't intend on becoming a junkie, I didn't intend on catching the habit—nothing like that. I just wanted to get the pain over with, but it was so excruciating. That's what happened like a downward spiral, everything from there just went down.

Pain was not a problem for these participants during recreational use initially. When pain became a problem, they needed opioids to treat their pain. When the prescribed amount of opioids were not enough to manage the pain, they would try to get more. When they no longer could obtain more prescription opioids, they started using heroin to manage their pain and to prevent withdrawal. This persistent pain and pain treatment with opioids created a downward spiral in their lives that they never experienced as a recreational drug user.

When pain preceded addiction, five out of nine participants in this subgroup did not use recreational drugs prior to first receiving opioids for the treatment of pain. They were given opioids from their health care provider for ear infection, fractured arm, back injury, neck pain, and dental pain. Once they received opioids for pain, they lost control of their use. One female participant stated her story of addiction started at 5 or 6 years of age, when her health care provider put her on an opioid for an earache. As an adult, she felt he was a wonderful man, but stated he did not understand addiction in her life. In her demographic questionnaire, she stated she had no family history of addiction. During the interview she stated she now maintained her sobriety, but had pain 24 hr a day. She described her pain in the context of coexisting addiction and pain, "that is like ... TNT, it's an explosion." A male participant explained he had a genetic predisposition to addiction. He received opioids for low back pain following a basketball injury when he was young. He remembered he liked the feeling of the pain medication. He said, "It was almost like I was screwed from the beginning you know. I have an extensive family history of addiction. It's opioids on my dad's side and alcohol on my mom's side." He believed his family history of addiction placed him at risk for drug abuse when exposed to prescription opioids.

Individuals who had pain before addiction were initially exposed to prescription opioids by their health care provider in an attempt to treat their pain. However, their narratives of abuse of prescription opioids and transition to using illicit substances, and then abusing prescription opioids and illicit substances was similar to those who started with addiction.

Inclination to Abuse of Prescription Opioids

Of the total study participants, 59% felt they would abuse prescription opioids if they were given them for the treatment of pain, 32% felt they would not abuse prescription opioids, and 9% did not know. This inclination to abuse prescription opioids or not may offer insight into the preference to abuse certain drugs. Factors identified among this subgroup to

influence their preferences were addiction preceding pain, pain preceding addiction, and recreational drug use.

Participants Would Abuse Prescription Opioids

Of the total study participants, 59% ($n = 20$) felt they would abuse opioids if prescribed to treat their pain. Of this subgroup, 52% experienced addiction before pain, and felt exposure to prescription opioids for the treatment of pain while on methadone for treatment of addiction, would most likely cause relapse. One participant stated, "I mean it might trigger relapse if I have a whole bunch of pills in my hand. Say I have 30 pills yeah, I might think about taking five, six of 'em. I'm an addict, it's in our minds." The composite trajectories of the group who experienced addiction first, revealed why relapse would occur. They were injured as a result of their substance abuse. They received prescription opioids from a health care provider for the treatment of pain. This resulted in the participants adding abuse of prescription opioids to their abuse of illicit substances. One participant stated he went from getting high, to treating pain, and getting high. Another participant had been abusing marijuana and crack prior to her chronic pain. She stated when her prescription opioid abuse became apparent; her health care provider said she would have to taper from the opioids. But she could not taper and started using heroin to cope with her pain. She quickly became addicted to heroin. The transition from one drug of abuse to another occurred without hesitation; she abused marijuana, crack cocaine, oxycodone products, and heroin. Another participant described his experience:

Chronic pain made my dependency even worse actually because I started using pain pills. Even before I was on the [methadone] program, I was using methadone 'cause I would buy it off the street. Go to the doctor get the pain pills, use those and the methadone and the heroin. So it brought on another addiction with the pain pills and living with that, living with drugs and addiction. Oh man! That's like a double hurt, a double whammy.

Of the 59% ($n = 20$) of the total study participants who felt they would abuse opioids if prescribed to treat their pain, 35% experienced pain before addiction and felt exposure to prescription opioids for the treatment of pain, even while on methadone for treatment of addiction, would most likely cause relapse. All were initially prescribed opioids by their health care providers and only 28% had histories of recreational use prior to their prescription opioids. No one used heroin in this subgroup, however when exposed to opioids for the treatment of pain, 71% transitioned to heroin.

Participants Would Not Abuse Prescription Opioids

Of the total study participants, 32% ($n = 11$) believed if prescribed opioids for pain they would not abuse them. Of this subgroup, 82% ($n = 9$) experienced addiction before pain, and all but one participant had pain related to their substance abuse pattern or recreational use. Approximately half of this subgroup abused illicit drugs and half abused illicit drugs and prescription opioids. Moreover, at the time of these interviews, approximately half the participants had regularly received prescription opioids, like Percocet® or Vicodin®, from a health care provider, and stated they did not abuse it and followed the opioid agreement with their one prescriber. One female participant stated there were two reasons she did not feel

she would abuse prescription opioids. These reasons included, (a) not starting out using or abusing prescription opioids, and (b) prescription opioids (morphine and oxycodone) did not make her feel the same way heroin made her feel. These participants in this subgroup started abusing illicit substances and did not abuse prescription opioids received for the treatment of pain. Prescription opioids and illicit opiates belong to the same class of analgesics, yet the participants continued to believe prescription opioids would not be a problem for them if they were needed for the treatment of pain.

In sum, understanding who will be successful with opioid therapy for treatment of pain is not simple. The participants stated in their narratives that people who abused prescription opioids in the past are at risk for taking more than prescribed, risking overdose or relapse if given them again. However, there were other participants who abused illicit substances who stated they would not abuse prescription opioids if needed for the treatment of pain. In their narratives, they stated it was important to treat pain and sometimes opioids are indicated for the treatment of their pain. The complex features of each individual participant may help health care providers provide individualized, compassionate, and safe care.

Discussion

Key findings were determined from the narratives of the participants in this study who had a well-defined addiction and who self-identified as living with chronic pain. These findings from the narratives presented (a) a pathway where addiction preceded their chronic pain leading to a coexistence of both; (b) a pathway where pain preceded their addiction leading to a coexistence of both; (c) more inclination to abuse prescription opioids if given them for treatment of pain, when they were first exposed to opioids by their physicians for the treatment of pain, leading to abuse of prescription opioids and subsequently heroin; and (d) less inclination to abuse prescription opioids if given them for treatment of pain if they first abused illicit drugs before pain ever occurred. These findings reveal an interindividual variability and further discussion follows.

Chronic pain was related to injuries that occurred while abusing illicit drugs or using illicit drugs recreationally. Many did not know they were injured, and some even chose not to seek health care. When they received prescription opioids for treatment of their pain, they added these to their drugs of abuse and took more than prescribed. When they were no longer able to receive prescription opioids for their pain, they obtained illegal opiates for their pain and to sustain their addiction. When pain became chronic, addictions became worse. This finding also occurred in another study where the study participants found that treating their pain with opioids reactivated their former addiction to alcohol or marijuana and expanded their addiction to prescription opioids (Sorajjakool et al., 2006). This study and the Sorajjakool et al. (2006) study support the possibility that some individuals treated for pain with opioids may experience an activation of a previous addiction.

In the narratives of those who experienced pain first, all these participants were initially prescribed opioids by their health care provider for pain management and they related that addiction quickly occurred. This confirmed the findings of Rhodin et al. (2006) and Morasco and Dobscha (2008). However, in this study there were two trajectories of experiences for

those who experienced pain first. One trajectory was recreational use of illicit substances (not heroin), where they felt they could quit their recreational use at any time. Their recreational use had no negative impact and they remained functioning in society. When they were prescribed opioids for the treatment of pain, they were surprised at their loss of control. Another trajectory was participants initially prescribed opioids by their health care providers for pain management and did not have any exposure to illicit recreational use. They reported in their narratives the abuse of prescription opioids, and eventual transition to abuse of illicit substances and prescription opioids. This finding is comparable to a study by Reid and colleagues (2002), where it was found that 24% of Veterans Administration patients and 31% of primary care center patients had medical records documentation of prescription opioid abuse behaviors, however, the transition to abuse of illicit substances was not mentioned.

When pain preceded addiction to illicit substances, all participants discovered they could not get off their prescription opioids used to treat pain. They used more pain medications than were prescribed and had prolonged use of these prescriptions. Similar findings were reported in a cohort study of people with chronic pain who overdosed on their opioid analgesics (Dunn et al., 2010). Only 13.7% of the cohort had histories of substance use disorder, while 86.3% had never abused substances before. While all participants in the study eventually developed addiction, not all of them had this disorder prior to being placed on prescription opioids for pain. Whether individuals like those in this study experienced addiction first or pain first, the convergence resulted in aggressive pursuit of heroin, or prescription opioids. One participant concluded it was like a “double whammy.” When addiction was out of control, pain was worse; when pain was out of control, addiction was worse. Each caused a reactivation of the other.

Most of the total study group of participants stated that they would abuse prescription opioids if they were exposed to them for the treatment of pain. This confirms the Trafton et al. (2004) study of 228 Veterans Administration patients with substance use disorders with and without pain. In the Trafton et al. study, results showed that increased pain intensity may have driven behaviors related to relief-seeking through abuse of prescription opioids and illicit drugs to protect themselves from further pain. In this current qualitative study, 59% of the total study group of participants believed they would abuse prescription opioids if prescribed for pain management although, 32% said they would not. Of the 32%, some of these participants were taking opioids for pain management, some from legitimate prescription, and some illegally obtained, and they reported that it had not caused them to relapse. One female participant summarized that she controlled the Percocet® but heroin and cocaine controlled her. Having an underlying substance use disorder does not mean that taking prescription opioids for the treatment of pain will always exacerbate an addiction. This further supports that individualizing the pain management treatment for those with coexisting addiction and pain is essential.

There is a gap in the literature on the overlap of addiction and pain, yet these two conditions are on the rise in the United States. There are enormous health benefits gained in understanding the path that individuals take in developing the coexistence of these two problems. This is the first step in discovering the dimensions of coexisting addiction and

pain. Narratives in this study provided rich descriptive qualitative data, however, the findings cannot be generalized beyond a sample with similar life circumstances to those treated in a Midwest methadone clinic. Winter weather conditions during the data collection period were severe and could have kept those in pain from attending the interviews. When the analytic interpretations of the participants' experiences can be recognized as the reader's own, then credibility of finding is increased (Hall & Stevens, 1991). Within this single interview technique, there was no possibility to have the participants verify the study's findings. A follow-up interview of the participants would establish credibility and authenticity.

This study clarified the dimensions and presented pathways individuals took in developing coexisting addiction and pain. This is significant to nursing and to nurses with prescriptive authority in knowing the unique needs of individuals who experience the interplay of these two conditions. Nursing care of individuals with addiction and pain require knowing that pain management taken seriously will not always worsen addiction in those with a history of addiction, and that listening to their stories is not time wasted. This study provided the voices of individuals suffering from addiction and pain, revealing their world of escape, their injury-prone lifestyles that contributed to their pain, their propensity to abuse their prescription opioids alone, or in combination with their illicit substances. When patients experience addiction before their pain, the participants revealed high risks for relapse taking prescription opioids for pain. This confirmed the findings of Morasco and Dobscha (2008), where those with histories of addiction were 3 to 6 times more likely to have aberrant medication-related behaviors. However, these narratives in this qualitative study also revealed there were possible exceptions to the rule, as 32% said that they felt they would not abuse prescription opioids if needed for the treatment of pain and 9% were not sure. Furthermore, if there is no history of addiction, and pain persists where opioids are needed for relief, there may still be problems of addiction. The health care provider cannot assume that no history of addiction makes prescribing opioids for pain low risk. As health care providers we should provide sensitive and appropriate care for patients with coexisting addiction and pain that is individualized and safe. There may also be a message for policy makers. Prescription opioid misuse, abuse, and diversion pose huge financial burdens on society. While there may be gain in function from using opioids for the treatment of chronic pain in people with addiction; any gain may be offset by prescription misuse, abuse, and diversion, which costs the United States nearly US\$1 billion per year (White, Birnbaum, Rothman, & Katz, 2009). Understanding the unique health care needs of this population will help tailor interventions to meet their specific needs for addiction and pain. More research is needed to accurately inform policy makers.

Future research questions arise from this study. What are the experiences of patients receiving opioids for the treatment of chronic pain in the primary care setting who do not have the disease of addiction as comorbidity, but later develop problems with their use that may imply addiction? Is recreational use different from drug abuse? What risk does recreational use of illicit substances have for those receiving prescription opioids for pain? If further studies reflect the concept of recreational use, recreational use will need to be defined and potentially used in a screening tool to determine risk.

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Table 1**Steps in Data Analysis.**

Read narrative and listen to audiotapes (noting vocabulary, vocal intonation, and body language).
Make notes in typed narrative from field notes.
Write narrative summaries for each participant (structural analysis: how they told their story).
Record key verbatim quotes in each interview story. Look for themes.
Write trajectories for each participant (in an order in which they told their story).
Document themes between participants looking at similarities and differences among participants.
Compare and contrast stories told by subgroups: ethnicity/race, age, socioeconomic circumstances, gender, education, and work status.
Find exemplar narratives.
Color code themes for each participant based on documented themes.