



“I’m Not the Same Person Anymore”: Thematic Analysis Exploring Experiences of Dependence to Prescribed Analgesics in Patients with Chronic Pain in the UK

Louise S. Norton · Bridget Dibb

Received: July 2, 2023 / Accepted: August 29, 2023 / Published online: September 26, 2023
© The Author(s) 2023

ABSTRACT

Introduction: The rising issue of dependence to prescribed pain medication for patients with chronic pain has been highlighted in the literature; however, there is a dearth of research exploring the patient perspective of this dependence in the United Kingdom (UK). This exploratory qualitative study aimed to investigate experiences of prescribed analgesic dependence in patients with chronic pain in the UK.

Methods: Semi-structured interviews were conducted with nine UK-based participants (eight females, one male) with a mean age of 44, who experienced chronic pain and identified as dependent to their prescribed pain medication. The interviews were recorded and transcribed verbatim and the data analysed using thematic analysis.

Results: Three main themes emerged, including perceptions of dependence, interactions with others, and interactions with medical professionals. The findings revealed how the

experiences focused on the participants’ own perception of their dependence, such as its perceived impact on their life and how the dependence began, and the relation of the dependence to their social environment, for example, doctor–patient relations.

Conclusions: These findings suggest practical implications for the management of dependence such as, raising awareness of the risks of dependence with these medications in the UK, and stricter observation of those taking the medications to identify dependence issues early.

PLAIN LANGUAGE SUMMARY

A growing number of people with chronic pain are prescribed analgesics (painkillers) by a medical professional to manage their pain; however, these painkillers are often addictive and can cause dependence for those taking them. Despite the growing number of dependent patients, there is a lack of research into this type of dependence in the United Kingdom (UK). This study aimed to speak to people affected by this dependence and understand their point of view. Nine people were interviewed. The interviews were recorded and transcribed. Their words were analysed using thematic analysis, which helps to find the

Louise S. Norton and Bridget Dibb are co-first authors.

L. S. Norton (✉) · B. Dibb (✉)
University of Surrey, Guildford, Surrey GU2 7XH,
United Kingdom
e-mail: nortonl55@outlook.com

B. Dibb
e-mail: b.dibb@surrey.ac.uk

common themes in experiences. Three themes were developed including: what they thought of their dependence, how they felt their dependence affected their relationships with other people, and how relationships with doctors interplayed with their dependence. Their experiences were mainly negative and suggest improvements could be made in the UK healthcare system to support these individuals and help prevent this type of dependence.

Keywords: Analgesic dependence; Chronic pain; Prescribed pain medication; Thematic analysis

Key Summary Points

Why carry out this study?

There has been a marked increase of patients with chronic pain becoming dependent on prescribed analgesics internationally. However, individuals' experiences of this phenomenon have not been explored in depth in the United Kingdom (UK).

The aim of this study was to shed light on the experience of iatrogenic dependence and explore how insights of patients with chronic pain could inform public understanding of this dependence and healthcare practices.

What was learned from the study?

The thematic analysis method revealed three themes: perceptions of dependence, interactions with others, and interactions with medical professionals.

The results showed the complex stigma facing patients dependent to medically prescribed painkillers. Their experiences also indicated a need for changes in patient care.

INTRODUCTION

An estimated 35–51.3% of individuals experience chronic pain in the UK [1]; 60–80% of those with chronic pain use pain relief medication [2]. However, this is problematic, as pharmacological treatment for chronic pain usually involves potentially addictive substances such as nonsteroidal anti-inflammatory drugs [3], gabapentinoids [4] and most notably opioids [5]. This places people experiencing chronic pain at risk, as prescriptions for these painkillers have been climbing in the United States (US), Australia and Europe [6]. Indeed, this increase has been associated with heightened levels of overdose and misuse of prescription painkillers, particularly with opioid-based medications [5, 7], with up to 25–50% of patients who use them becoming dependent [8].

In the US, the 'opioid crisis' has led to increasing opioid abuse and overdose [7–9]. This epidemic has been determined as chiefly due to the over-prescription of opioid-based painkillers in the 1990s primarily administered for chronic pain by the US Department of Health and Human Services [as cited in 10]. Research in the US has explored the experiences of those dependent, including patient response to dependence treatments [11, 12], societal stigma towards dependence [13], and poor relationships with healthcare providers who use derogatory labels like "drug seekers" [14]. However, much less research has been conducted in the United Kingdom (UK) despite mortality rates relating to prescribed opioid painkillers in England, Wales and Scotland displaying similar trends to the US [15], and a 48.9% increase in opioid-related hospitalisations between 2008 and 2018 in England [16]. The UK may not yet be in an epidemic like the US, but this possibility cannot be ruled out [17].

Researchers have called for a "radical rethink" regarding increasing opioid prescriptions in the UK [9] and highlighted the misconceptions surrounding dependence to prescribed pain medicine as opposed to illicit substances [18, 19]. Hence, qualitative research on the experience of dependence to prescribed

painkillers in patients with chronic pain in the UK could allow for greater dialogue and awareness of the issue and assist in doctors' understanding of analgesic dependence as well as providing contextual information to enable them to provide optimum care for patients.

Various theoretical frameworks have been utilised in an attempt to understand iatrogenic dependence. Marlatt and Donovan [20] argued that identifying a taxonomy of reasons for an individual's use of a substance can aid our comprehension of their dependence. Indeed, Weiss et al. [21] utilised this framework for prescription opioid dependence in those with chronic pain and observed for physical pain and avoidance of withdrawal to be the two predominant reasons for maintaining the dependence.

Models of medication adherence can also explain this dependence. For example, the Necessity-Concerns Framework (NCF) has been previously applied to prescribed medications [22, 23]. This framework proposes that medication adherence is determined by a cost-benefit analysis in which beliefs regarding the necessity of the medication are weighed against concerns of its potential adverse effects. An individual is suggested to be adherent if the medication's necessity is perceived to be more important than its concerns [22, 23]. Alternatively, the Model of Medicine Taking [24] specifies how individuals can be acceptors (active or passive) or rejecters of medicine-taking; an active acceptor will evaluate the medicine before using in a similar fashion as suggested by the NCF, whilst passive acceptors simply take the medicine often due to trust in their prescriber [25] who can act as paternalistic figures [26]. Therefore, an active acceptor may continue to take the medication, despite a dependence, based on their evaluation of its necessity, whilst a passive acceptor may continue to use medication after dependence onset due to confidence in their doctor. Despite multiple theoretical models showing potential for explaining the dependence, it remains unclear as to which model best explains the behaviour; this limits the development of theory-based interventions for approaching this issue.

This study was exploratory and used semi-structured interviews to examine experiences of

dependence to prescribed pain medication in patients with chronic pain in the UK. A qualitative approach was adopted, as it was deemed most appropriate to capture in-depth and descriptive accounts of these experiences. Indeed, it has been emphasised how qualitative methods can encapsulate such narratives as well as promoting meaning and understanding of such experiences [27]. Furthermore, it has been suggested that these narratives in conjunction with quantitative research can allow for a more comprehensive view of such a dependence [13]. Thus, the thematic analysis of these responses could potentially help others who are prescribed medication for pain or even help to inform UK medical practices.

METHODS

Research Design

A qualitative design was used to explore individuals' experiences of dependence to prescribed pain medication for chronic pain in the UK. Data were collected using semi-structured interviews and analysed using thematic analysis (TA) [28].

Study Participants

The total sample comprised nine participants (eight female, one male). This is consistent with the recommended sample sizes for such studies and ensures enough data for data saturation [29]. The majority were White British with a mean age of 44.11 (range: 24–56, SD = 9.32). Participants also completed the Severity of Dependence Scale (SDS; open access) [30] to assess their degree of dependence. SDS scores have the potential range of 0–15 with a higher score indicating greater dependence severity [31]. The participants' mean SDS score was 8.78 (range: 4–13, SD = 3.49) which indicated dependence using Deluca et al.'s recommendation of a score of over 5 for codeine [32], a commonly prescribed painkiller [33]. All demographic information including chronic pain conditions and medications used can be found in Table 1.

Table 1 Demographic variables of participants

Participant pseudonym	Gender	Age range	Condition or source of pain	Medication currently prescribed for pain	SDS score
Ellie	F	18–24	Fibromyalgia and chronic fatigue syndrome (CFS)	Tramadol, pregabalin	8
Hazel	F	45–54	Car accident and degenerative disc	Tramadol, baclofen, amitriptyline, gabapentin	5
Emma	F	35–44	Rheumatoid arthritis, fibromyalgia and chronic back pain	Tramadol, fentanyl, duloxetine	12
Annie	F	35–44	Fibromyalgia	Pregabalin, amitriptyline, tramadol, paracetamol, duloxetine	12
Cathy	F	45–54	Fibromyalgia, car accident, work injury affecting right side of body, sciatica, pinched nerves and arthritis	Buprenorphine, duloxetine and co-codomal	12
Angela	F	55–64	Rheumatoid arthritis, osteoarthritis, hip replacement and fibromyalgia	Sodium diclofenac, ibuprofen, venlafaxine, co-codomal, paracetamol	7
Karen	F	45–54	Complex regional pain syndrome and amputation	Pregabalin, tapentadol (moderate- and fast-acting release), ketamine, amitriptyline	6
Adam	M	45–54	Car accident resulting in back injury	Oxycontin, nabilone, amitriptyline	4
Laura	F	45–54	Car accident resulting in broken neck, fibromyalgia, CFS, osteoporosis and arthritis	Fentanyl patch, tramadol, co-codomal, amitriptyline, duloxetine	13

SDS severity of dependence scale

Ethical Considerations

This study received a favourable ethical opinion from the University of Surrey's Faculty of Health and Medical Sciences Ethics Committee (FER-1819-009). Participants gave their consent to participate in this study and for the publication of the anonymous data.

Procedure

Participants who were unknown to the researchers were recruited using purposive and snowball sampling. A description of the study was posted on chronic pain support website

forums and Facebook groups for those with chronic pain or those dependent on prescribed pain medications. The inclusion criteria required participants to self-identify as being currently dependent on their prescribed pain medication, over 18 years of age, able to speak English, and UK-based to take part. No incentive or compensation was offered in return for participation. Potential participants e-mailed if they were interested in participating and were sent an information sheet in return, which detailed the rationale for conducting the research as well as contact information and credentials of the researchers. Ethical approval was received from Surrey University's Ethics

Committee prior to performing the interviews to ensure appropriately related questions were asked and to be aware of the emotional distress which could ensue from the interview.

The interviews followed a semi-structured format, where the interviewer used a flexible interview guide with open questions; for example, ‘Can you tell me how you came to be dependent and what is it like for you?’, to ensure the participants were not asked leading questions and could answer based on what was most important to them. This semi-structured approach allowed for more open dialogue between the researcher and participant and for the participant to express their thoughts more freely. The open questions were also designed to maintain an atheoretical approach and were not led by previous research or theory. Prompts were also used when necessary to encourage participants to expand their answers. The interviews were conducted by LN (a student trained in qualitative methods). Both authors were involved in the analysis and development of the themes (BD, an experienced qualitative researcher, supervised the study). The interviews took place either via telephone or in person at the University of Surrey; the interviews were conducted one-to-one, except for one case where the participant’s carer was present. The interviews each took up to an hour and were recorded and transcribed verbatim. Participants were assigned pseudonyms to maintain anonymity. A reflexive approach was taken throughout to reduce bias at both data collection and analysis stages.

Analysis

Thematic analysis, based on Braun and Clarke [28], was used to inductively identify themes. It was chosen as the analytic method as it is not bound to an existing theory and consequently suitable for an exploratory study as well as being recommended for exploring individuals’ experiences [34]. A critical realist stance was adopted as the epistemological approach and thus it was understood that the experiences described by participants represented reality for them however this reality could be influenced by the

individual’s context. This allowed for appreciation of the importance of their experiences but also the heterogeneity of such experiences. This is particularly important for the current study, as such experiences have not yet been commonly explored.

The TA was performed in a set of stages as advised by Braun & Clark [28]. Every transcript was read multiple times to ensure familiarity with the content. The next stage involved initial coding of the data. In order to ensure depth to the analysis, both semantic and latent analysis took place [28]. The following stage was comprised of clustering the codes into themes and subthemes. Both similarities and differences of perspectives between participants within these themes were noted. Theme development was discussed within the research team to maintain rigor and to ensure that a reflexive approach was taken.

RESULTS

Three themes were developed using TA: *Perceptions of dependence, interactions with others* and *interactions with medical professionals* (Table 2).

Theme 1: Perceptions of Dependence

Individual perceptions and experiences of dependence to pain medication were frequently discussed amongst all participants. Participants described how they felt the medication itself impacted and often limited their ability to experience life. Below, Karen expressed how pervasive she found her dependence as she felt she was not fully present and instead felt removed from her life,

“You’re not living a life really. You’re doing it through a haze of, ‘I don’t care. I’m off my face,’ sort of thing. I don’t know why anyone would ever recreationally do it to be honest.”
(Karen)

Karen describes clearly how she feels her dependence inhibits her from actively engaging in her life due to the side effects of the medication. She feels she is instead a passive bystander who can only witness life obscurely

Table 2 Master table of themes**Themes**

Theme 1: Perceptions of dependence

Theme 2: Interactions with others

Theme 3: Interactions with medical professionals

through a “haze.” Similarly, Emma’s comment shows the magnitude of the experience for her. The effects of the medication left her feeling like a completely different person,

“I’m not the same person anymore. I’m a completely changed person.” (Emma)

Below, Annie described the dominating nature of her dependence, where she felt the burden of being tied to a 4-hourly schedule,

“Your whole life is now, you know, based every four hours making sure you remember to take medication.” (Annie)

Despite the negative effect of the medication, participants also spoke of how they needed to take the medication to manage their pain. Some acknowledged that there may be side effects or harm from the medication but their need for the medication to manage the pain outweighed consideration for any negative effects to their physical health, as Karen’s comment below shows,

“I don’t know what... damage they might be doing to my body but...whilst I’m in pain, I have to take them.” (Karen)

Laura likewise noted her reliance on the medication and rationalised it as a need for her to function,

“It might be addiction but it’s also necessary...because I wouldn’t be able to function without it.” (Laura)

The extent of this dependence to the medication was likened to leaving her husband, which clearly shows the importance of the relationship with her medication,

“Once you’ve been on something for so long, you depend on it. It would be like

divorcing my husband now... What would I do without it, him?” (Laura)

While participants spoke of the need for the medication, they also wished they could live without it. They viewed their dependence negatively and wished for it to end,

“If somebody could say there’s a magic wand, and I can fix it and no more pills, it’d be fantastic... It’s something I don’t want to be in.” (Cathy)

The participants attempted to make sense of their unwanted dependence by querying the reasoning for being prescribed the medication initially,

“I want to know, why did they start me on this medication? Why did the doctors do this to me?” (Emma)

Participants also frequently mentioned the lack of alternative options for pain management in the National Health Service (NHS), which may have reinforced the necessity of medication,

“If you’re relying on the NHS alone, bar drugs, there’s not a lot of help.” (Annie)

However, Laura suggested that painkillers are the only method suitable for alleviating pain when asked if she had tried non-medicinal alternatives,

“Are you a believer in that? Because I’m not. I’ve tried. I’ve tried the acupuncture, I tried this pacing yourself, I tried everything. It’s real pain.” (Laura)

On the other hand, Cathy observed the implausibility of other options, not due to their perceived limited efficacy, but how they are financially unattainable,

“I know there are alternatives but the alternatives, like the cannabis oil, and everything is so expensive, and I can’t afford it.” (Cathy)

Thus, the limitations posed by medications are overridden by their perceived necessity, which is further facilitated by the lack of viable treatment options for pain. Whilst the

participants described their dependence as necessary to maintain physical health, some emphasised that it was solely a physical dependence and showed reluctance in being seen as psychologically dependent. Angela's quote below is an example of this and alludes to the stigma and stereotypes associated with dependence (to be explored in Theme 2),

“Dependency, in my case, is I have to have them or I’m going to be very very unwell... but I know for a lot of people, dependency means they’re sort of hooked on them.”
(Angela)

Theme 2: Interactions with Others

Participants' experiences of dependence related to their social environment both through others' appraisal of their dependence and how participants disclosed their dependence to others. Participants felt that dependence on pain medication was associated with the negative stereotypes of those addicted to cocaine and similar illicit drugs. The comment from Annie below shows how she felt that society does not distinguish between different types of addiction,

“I suppose it’s inbuilt into society... If you’re addicted to drugs, you’re a druggie.”
(Annie)

Similarly, Karen described those who are addicted to illicit substances as those who ‘wreck’ their lives and engage in stealing,

“When people talk about drug dependency, you think about the addict on the street. You think about the ones that are really wrecking their lives in drugs and robbing... and needing a fix. Whereas we are on that sort of level of medication, but... I don’t see myself as that sort of an addict.” (Karen)

This is further magnified by the view that the participants felt others did not understand how they could be dependent when the drug in question had been prescribed by a medical doctor,

“If I was on speed or cocaine or whatever and say, ‘oh yeah I do that for pain.’ Then they’d think, ‘hmm, yeah, yeah yeah.’ Wouldn’t they? But I think when it’s doctor drugs...people don’t tend to think like that.” (Laura)

In addition, participants were very aware that dependence to substances is not a topic spoken about openly. Laura described it as still a taboo subject,

“[Dependence] is taboo still. Which I don’t think it should be in this day and age. But it’s still a pretty taboo subject.” (Laura)

This perception of lack of understanding from others and an awareness of the stigma associated with being dependent on pain medication influenced who they disclosed their dependence to. Annie describes this below,

“It would only be a select few friends that I would talk to about that...you feel a little bit ashamed to be honest because then you think, ‘well, I know better than a junkie.’”
(Annie)

She also described feeling ashamed and criticised herself for being at all similar to a ‘junkie’ as she should have ‘known better.’ Further evidence of internalising the negative stereotypes is shown in Laura’s comment where she described herself as having a weakness,

“It is a weakness... I don’t like admitting I have a weakness.” (Laura)

Theme 3: Interactions with Medical Professionals

All the participants spoke of their interactions with their doctor, with the majority emphasising its negative nature. Some participants attributed the cause of their dependence to their doctor and many felt ignored and misunderstood by the medical profession, as shown by Emma’s comment below,

“He wouldn’t listen to me at all. He wasn’t even trying to understand me. It was alright for him to sit behind a desk...and

say things but... he's not in my shoes."
(Emma)

The negative interactions also included a lack of communication, which in Ellie's case, she attributed as having serious consequences,

"I mean the only time I got spoken to was after my overdose and, I mean it's a bit late for that really isn't it? ...the overdose should have been prevented." (Ellie)

Participants also spoke of a lack of continuity between the doctors, which they listed as a reason for their dependence. Angela detailed how she felt seeing so many different doctors could allow a dependence to be missed,

"if [patients are] seeing a different doctor every time, that questioning might not happen until much much later by which time you know, they've become properly dependent physically on them...and psychologically as well." (Angela)

There were also comments suggesting that the prescribing pattern of some doctors was a contributing factor. In these situations, the prescription was not tailored to the patient, but offered as the standard treatment,

"Some of the other doctors, get a bit fixed in their ways...they know what works for most people. Therefore, that's what they will immediately prescribe. Whereas my doctors' much more willing to listen to me." (Angela)

Participants also acknowledged that part of the problem is the tendency to not query the doctor's advice but to do as they were told,

"I would just you know toddle along, doing as I was told from the doctor." (Annie)

However, this trust was not held by all participants. Angela shows an awareness for the need to have a more active role in your own health,

"You have to sort of work as a team. You can't rely on just being looked after like your mum would have looked after you when you were tiny." (Angela)

DISCUSSION

This research aimed to explore individuals' experiences of dependence to prescribed pain medication for chronic pain in the UK. Three themes were developed based on the participants' narratives. These included: perceptions of being dependent, interactions with others, and interactions with medical professionals. All themes were primarily negative.

Participants' negative attitudes towards their dependence were shown through their descriptions of the dependence as monopolising their lives whether that be through a medication schedule or how it governed their ability to fully engage in their lives. However, the perceived need for the medication and lack of alternative non-medicinal treatments for chronic pain in the UK outweighed the negative threat to their health and self-view. Their attitude was also likely influenced by their experience of the stigma associated with being dependent on drugs. This supports previous literature which recognised the effects of the dependent stereotype and how it can lead to dependent individuals feeling marginalised by society [5, 13].

Participants also commented that the perceived stigma discouraged them from disclosing their dependence to others. This is concerning, as one of the main reasons for disclosure for many conditions is the need for support [35, 36], and this could add to the lack of awareness surrounding dependence to prescribed pain medication [37]. Furthermore, some of the participants noted how others did not consider prescribed analgesic dependence to be possible, as it occurs legitimately via doctor administration rather than illicitly. This supports previous research showing the difference in perceptions of iatrogenic and illicit dependence [18, 19] and could also be a contributing factor for the lack of awareness of prescribed painkiller dependence.

Doctor–patient relationships were frequently remarked upon and alluded to the potential weight of the doctors' influence on experiences of dependence. The majority of participants portrayed a negative relationship with their doctor due to feeling that they were not listened

to and were misunderstood in their dependence, hence affirming past research (e.g. [10]). However, these accounts also add to this literature, as they proposed further reasons for difficulties in these relations: hierarchical distance between doctor and patient, doctors becoming complacent in treatment choice based on habitual prescribing behaviour and seeing multiple doctors resulting in inconsistent consultations.

Several participants presented themselves as passive in their doctor–patient interactions and attributed their doctor as the overriding factor of their dependence. This corresponds to the ‘passive acceptor’, which is part of the Model of Medicine Taking [24] and demonstrates how some may view their doctor as the expert in the relationship [26]. This highlights the importance of shared decision-making in which doctor and patient share responsibility in treatment decisions [18] to prevent doctors being the dominant influence. Moreover, this issue of patients as ‘passive acceptors’ could negate the Necessity Concerns Framework, as patients may not perform a cost–benefit analysis but simply take medication in response to a doctor’s instructions. This indicates a need for doctors to be more vigilant when prescribing pain medication due to the potential of dependence as patients may not actively recognise this risk. It should also be noted that none of the participants were ‘rejectors’ of the medication but instead all either passive or active acceptors.

Participants’ experiences also shed light on their rationalisation of how their dependence began and was maintained which supports former research. Firstly, participants stated physical pain and withdrawal avoidance as reasons for dependence, both of which are included in Weiss et al.’s [21] taxonomy of reasons for dependence. Some participants also appeared to perform a cost–benefit analysis in which they deemed their concerns over the potential harm of dependence to be less important than the medication’s necessity, and hence illustrating how the concept of the ‘active acceptor’ [24] and Necessity-Concerns Framework (NCF) [22, 23] can be applied to analgesic dependence. Their responses added to the concept of medication necessity, as they revealed it may not be

based solely on pain relief but is also facilitated by the lack of alternative non-medication-based options for chronic pain available on the NHS. On the other hand, neither Weiss et al.’s [21] taxonomy nor the NCF [22, 23] highlighted the considerable influence of other factors, such as the impact of doctors and perceived social attitudes of dependence, which the participants identified for their dependence.

The insights provided by these individuals’ accounts suggest ways in which to improve future patient experiences in the UK. First, raising public awareness about how prescribed analgesics can inadvertently lead to dependence could help in reducing societal stigma. Raising awareness would also inform patients of the risks of dependence to these medications allowing for them to be better equipped for joint treatment decisions with their healthcare professional. Second, this need for shared decision-making is clearly demonstrated via multiple participants being passive in their medical treatment. This could be improved by doctors being more observant and thoroughly educating patients on painkillers and other treatment options and advising them on potential risks. Indeed, multiple participants highlighted the lack of non-medicinal options for chronic pain offered through the NHS and so other options, such as physical therapy, could be put forward before administering analgesics. This could in turn help patients to feel more confident and supported in their medical choices and lessen the feeling of a hierarchical barrier between them and their doctor.

The main strength of this research was the use of interviews, which gave voice to the participants and enabled them to give an in-depth account of their own experiences of iatrogenic dependence with minimal influence of the researcher. Moreover, the researcher was reflexive throughout the study in order to increase confirmability. However, a few limitations must also be noted. First, the sample size of nine was small; however, this is within the recommended sample size for such studies [29] and the participants’ interviews offered rich insights with considerable depth. In addition, the nine participants had heterogenous pathologies causing their chronic pain such as

fibromyalgia and arthritis. These varying pathologies may have factored into the patient's experience of dependence as the source and level of chronic pain would have affected the particular painkiller(s) prescribed as well as their dosage. Second, whilst participants consented to being interviewed, they may have still been influenced by a social desirability bias and hence may have altered their accounts in some way to avoid embarrassment, thus resulting in reduced credibility. Also, there is a need to be cognisant of the recruitment method as the majority of participants were recruited online via social media. This could have led to selection bias, as individuals without Internet access may not have been able to participate; these individuals may have had different perspectives on dependence due to being without the Internet and social media, which can provide helpful information about dependence as well as online support. Therefore, future research could recruit via different means, such as doctors' surgeries, in order for the study to be more accessible and inclusive. Furthermore, other psychosocial factors, which could have contributed to the participants' experiences of dependence such as emotional support from romantic relationships and support in their work environment, were not investigated within this study and could aid in giving a more holistic picture of their experiences.

CONCLUSIONS

This exploratory research gives voice to those living with chronic pain and their diverse experiences of dependence to prescribed pain medication in the UK. Their principally negative accounts shed light on the complexity of iatrogenic dependence in how it is often viewed differently from other forms of dependence; this is heavily due to legally prescribed medicines and dependence being seen by society as mutually exclusive and therefore not possible. Participants also felt misunderstood within their own social networks and unsupported by the medical profession. Increased public awareness of dependence to prescribed painkillers could encourage patients with chronic pain and prescribers to be

more cognisant of the treatment choices and their risks, as well as encouraging greater support for those dependent.

ACKNOWLEDGEMENTS

We are very grateful to the participants who gave their time pro bono to support our research. Their honest accounts help pave the way for future patients who encounter this dependence to help them be better heard and supported.

Author Contributions. BD, Senior Lecturer in Health Psychology, conceived the idea for the research. All authors contributed to the study's design. Material preparation, data collection and analysis were performed by LN, an undergraduate Psychology student, with the support and active supervision of BD. Theme development occurred after discussion between both authors. The first draft of the manuscript was written by LN and both authors commented on further versions of the manuscript. Both authors read and approved the final manuscript.

Funding. No funding or sponsorship were provided for this study to be completed. The Rapid Service Fee and publication fees were funded by the University of Surrey, Guildford, UK.

Data Availability. Data sharing is not applicable to this article, as no datasets were generated or analysed during the current study.

Declarations

Conflict of interest. Louise Norton and Dr Bridget Dibb declare that they have no conflicting interests.

Ethical approval. This study received a favourable ethical opinion from the University of Surrey's Faculty of Health and Medical Sciences Ethics Committee (FER-1819-009). The study was performed in accordance with the Helsinki Declaration of 1964, and its later amendments. All subjects provided informed

consent to participate in the study and for their anonymised data to be published.

Open Access. This article is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, which permits any non-commercial use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/4.0/>.

REFERENCES

- Fayaz A, Croft P, Langford RM, Donaldson LJ, Jones GT. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. *BMJ Open* [Internet]. 2016;6:1–12. Available from: <http://bmjopen.bmj.com/>
- Broekmans S, Dobbels F, Milisen K, Morlion B, Vanderschueren S. Medication adherence in patients with chronic non-malignant pain: Is there a problem? Vol. 13, *European Journal of Pain*. 2009. p. 115–23.
- Adams E, Breiner S, Cicero T, Geller A, Inciardi J, Schnoll S, et al. A comparison of the abuse liability of tramadol, NSAIDs, and hydrocodone in patients with chronic pain. *J Pain Symptom Manag*. 2006;31(5):465–76.
- Public Health England. Advice for prescribers on the risk of the misuse of pregabalin and gabapentin [Internet]. 2014 [cited 2023 Sep 11]. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf.
- Ballantyne J, Stannard C. New addiction criteria: diagnostic challenges persist in treating pain with opioids. *International Association for the Study of Pain*. 2013;21(5):1–7.
- Eccleston C, Fisher E, Thomas K, Hearn L, Derry S, Stannard C, et al. Interventions for the reduction of prescribed opioid use in chronic non-cancer pain, vol. 2017, *Cochrane Database Syst Rev*. John Wiley & Sons Ltd; 2017. p. 1–14.
- Pourmand A, Jasani G, Shay C, Mazer-Amirshahi M. The evolving landscape of acute pain management in the era of the opioid crisis. *Curr Pain Headache Rep*. 2018. <https://doi.org/10.1007/s11916-018-0728-y>.
- Jay G, Barkin R. Perspectives on the opioid crisis from pain medicine clinicians. *Dis Mon*. 2018;64(10):451–66.
- The Lancet Public Health. Opioid overdose crisis: time for a radical rethink. *Public Health* [Internet]. 2022;7(3). Available from: www.thelancet.com/public-health.
- Wilson M, Shaw MR, Roberts MLA. Opioid initiation to substance use treatment: “they just want to feel normal.” *Nurs Res*. 2018;67(5):369–78.
- Heavey S, Chang Y, Vest B, Collins R, Wiczorek W, Homish G. ‘I have it just in case’—naloxone access and changes in opioid use behaviours. *Int J Drug Policy*. 2018;1(51):27–35.
- Potter J, Dreifuss J, Marino E, Provost S, Dodd D, Rice L, et al. The multi-site prescription opioid addiction treatment study: 18-month outcomes. *J Subst Abuse Treat*. 2015;48(1):62–9.
- St Marie B. Health care experiences when pain and substance use disorder coexist: “just because I’m an addict doesn’t mean I don’t have pain.” *Pain Med*. 2014;15(12):2075–86.
- Upshur CC, Bacigalupe G, Luckmann R. “They don’t want anything to do with you”: patient views of primary care management of chronic pain. *Pain Med*. 2010;11(12):1791–8.
- Giraudon I, Lowitz K, Dargan P, Wood D, Dart R. Prescription opioid abuse in the UK. *Br J Clin Pharmacol*. 2013;76(5):823–4.
- Friebel R, Maynou L. Trends and characteristics of hospitalisations from the harmful use of opioids in England between 2008 and 2018: Population-based retrospective cohort study. *J R Soc Med*. 2022;115(5):173–85.
- Stannard C. Opioids in the UK: what’s the problem? *BMJ*. 2013;347:f5108.
- Buchman DZ, Ho A, Illes J. You present like a drug addict: patient and clinician perspectives on trust

- and trustworthiness in chronic pain management. *Pain Med.* 2016;17(8):1394–406.
19. Byrne MH, Lander L, Ferris M. The changing face of opioid addiction: Prescription pain pill dependence and treatment. Vol. 34, *Health and Social Work*. National Association of Social Workers; 2009. p. 53–6.
 20. Marlatt G, Donovan D. *Relapse prevention*. 2nd ed. New York: Guilford; 2005. p. 1–20.
 21. Weiss R, Potter J, Griffin M, McHugh R, Haller D, Jacobs P, et al. Reasons for opioid use among patients with dependence on prescription opioids: the role of chronic pain. *J Subst Abuse Treat.* 2014;47(2):140–5.
 22. Horne R, Weinman J. Patients' beliefs about prescribed medicines and their role in adherence to treatment in chronic physical illness. *J Psychosom Res.* 1999;47(6):555–67.
 23. Horne R, Chapman SCE, Parham R, Freemantle N, Forbes A, Cooper V. Understanding patients' adherence-related Beliefs about Medicines prescribed for long-term conditions: a meta-analytic review of the Necessity-Concerns Framework. *PLoS ONE.* 2013;8(12):e80633.
 24. Pound P, Britten N, Morgan M, Yardley L, Pope C, Daker-White G, et al. Resisting medicines: a synthesis of qualitative studies of medicine taking. *Soc Sci Med.* 2005;61(1):133–55.
 25. Britten N, Riley R, Morgan M. Resisting psychotropic medicines: a synthesis of qualitative studies of medicine-taking. *Adv Psychiatr Treat.* 2010;16(3):207–18.
 26. Stavropoulou C. The doctor-patient relationship: a review of the theory and policy implications. In: *The LSE companion to health policy*. 1st ed. Cheltenham: Edward Elgar Publishing Limited; 2012. p. 314–26.
 27. Coyle N, Tickoo R. Qualitative research: What this research paradigm has to offer to the understanding of pain. *Pain Med.* 2007;8(3):205–6.
 28. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77–101.
 29. Hennink M, Kaiser B, Marconi V. Code saturation versus meaning saturation: how many interviews are enough? *Qual Health Res.* 2017;27(4):591–608.
 30. Gossop M, Darke S, Griffiths P, Hando J, Powis B, Hall W, et al. The severity of dependence scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. *Addiction.* 1995;90(5):607–14.
 31. Castillo I, González Saiz F, Lozano Rojas Ó, Landabaso Vázquez M, Lerma J, Castillo I. Estimation of cutoff for the severity of dependence scale (SDS) for opiate dependence by ROC analysis I. *Actas Esp Psiquiatr.* 2010;38(5):270–7.
 32. Deluca P, Foley M, Dunne J, Kimergård A. The severity of dependence scale (SDS) for codeine: preliminary investigation of the psychometric properties of the SDS in an online sample of codeine users from the UK. *Front Psychiatry.* 2021;1:12.
 33. Jani M, Birlie Yimer B, Sheppard T, Lunt M, Dixon WG. Time Trends and prescribing patterns of opioid drugs in UK primary care patients with non-cancer pain: A retrospective cohort study. *PLoS Medicine.* 2020;17(10). <https://doi.org/10.1371/journal.pmed.1003270>.
 34. Braun V, Clarke V. *Successful qualitative research*. Los Angeles: SAGE; 2013.
 35. Stutterheim S, Shiripinda I, Bos A, Pryor J, de Bruin M, Nellen J, et al. HIV status disclosure among HIV-positive African and Afro-Caribbean people in the Netherlands. *AIDS Care.* 2011;23(2):195–205.
 36. Dibb B. Assessing stigma, disclosure regret and posttraumatic growth in people living with HIV. *AIDS Behav.* 2018;22(12):3916–23.
 37. Carney T, Wells J, Bergin M, Dada S, Foley M, McGuinness P, et al. A comparative exploration of community pharmacists' views on the nature and management of over-the-counter (OTC) and prescription codeine misuse in three regulatory regimes: Ireland, South Africa and the United Kingdom. *Int J Ment Heal Addict.* 2016;14(4):351–69.