

Opioid Misuse: Recognizing Red Flags in Patient Behavior

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June 4, 2026

RECOMMENDED CITATION

mohammed loot (2026). *Opioid Misuse: Recognizing Red Flags in Patient Behavior*. Psychepedia. Retrieved from <https://psychepedia.arabpsychology.com/?p=17827>

Introduction and Conceptual Framework

Aberrant Opioid Medication-Related Behaviors (AOMRBs) refer to any actions taken by a patient receiving prescribed opioid therapy that deviate significantly from the established parameters of their treatment plan or the accepted norms of medical practice. These behaviors are critical indicators that warrant immediate clinical attention, as they often signal potential misuse, diversion, or the development of a severe Opioid Use Disorder (OUD). While the term is broad, encompassing activities ranging from minor non-adherence to outright fraudulent acts, the core function of identifying AOMRBs is to trigger a structured risk assessment designed to protect the patient from harm while ensuring appropriate pain management continues. The advent of widespread opioid prescribing for chronic non-cancer pain necessitated the development of this framework, recognizing that dependency and addiction are potential, though not inevitable, consequences of long-term opioid exposure.

The conceptual framework underlying AOMRBs distinguishes these observable actions from the underlying psychological or physiological state. A patient might exhibit aberrant behaviors due to factors entirely unrelated to addiction, such as inadequate pain control, misunderstanding of instructions, or pharmacokinetic variations requiring dose adjustments. Conversely, a patient actively struggling with OUD may temporarily mask or conceal these behaviors, making the assessment complex and requiring continuous vigilance. Therefore, AOMRBs serve as a crucial early warning system, prompting the clinician to delve deeper into the patient's context, history, and current needs rather than serving as a definitive diagnosis of addiction itself. The goal is to move beyond simple judgment and implement proactive strategies known as universal precautions in pain management.

Understanding AOMRBs requires acknowledging the inherent tension between providing compassionate care for chronic pain and fulfilling the professional and ethical obligation to prevent substance abuse and diversion within the community. The behaviors themselves are highly varied, necessitating a systematic categorization to ensure consistent clinical response. These behaviors typically involve manipulation of the prescribed regimen, such as taking medication more frequently or in higher doses than prescribed, seeking prescriptions from multiple providers simultaneously (known as **doctor shopping**), or engaging in activities that suggest the medication is being used for psychoactive effects rather than solely for pain relief. The identification and appropriate response to AOMRBs are cornerstones of responsible opioid stewardship in contemporary healthcare.

Context and Prevalence in Pain Management

The increased scrutiny surrounding AOMRBs is directly linked to the public health crisis surrounding opioid misuse and overdose deaths that escalated significantly in the late 20th and

early 21st centuries. Prior to this shift, opioids were sometimes prescribed without stringent monitoring protocols, leading to a rise in iatrogenic dependence and subsequent diversion into illicit markets. This historical context mandates that current pain management practices incorporate robust risk stratification and continuous monitoring, even for patients who initially present with low risk. The prevalence of AOMRBs varies widely across studies, primarily due to differing definitions of what constitutes "aberrant" and the specific patient populations examined, such as those in primary care versus specialized pain clinics.

Estimates suggest that significant AOMRBs, those strongly associated with potential misuse or diversion, may occur in 5% to 24% of patients receiving long-term opioid therapy for chronic non-cancer pain. However, less severe forms of non-adherence, such as occasionally running out of medication early or using a dose slightly higher than prescribed during a pain flare-up, are far more common. These high variability rates underscore the difficulty in establishing a precise metric for risk and highlight the need for individualized clinical judgment. Furthermore, the prevalence figures must be interpreted cautiously, as aggressive monitoring and restrictive prescribing practices, while intended to curb abuse, may inadvertently lead to under-treatment of legitimate pain or prompt patients to seek alternative, potentially illicit, sources of medication if their needs are not met within the medical system.

The clinical environment itself contributes to the complexity of AOMRBs. Patients often feel stigmatized or distrusted when subjected to frequent urine drug screens or pill counts, which can strain the therapeutic alliance essential for effective pain management. Effective practice requires acknowledging that while the majority of chronic pain patients use their medications responsibly, the presence of even low-level aberrant behavior necessitates intervention. This intervention must be framed not as punitive action, but as a necessary adjustment to the treatment plan aimed at safeguarding the patient's long-term health and preventing the progression toward a severe Substance Use Disorder (SUD).

Defining Aberrant Behaviors vs. Addiction

A fundamental distinction must be maintained in clinical practice between **Aberrant Opioid Medication-Related Behaviors** and the diagnosis of **Opioid Use Disorder (OUD)**, commonly referred to as addiction. Aberrant behaviors are merely observable actions that raise concern; they are markers or indicators of risk. OUD, conversely, is a complex, chronic, relapsing brain disease characterized by an inability to consistently abstain from opioid use, impairment in behavioral control, craving, and diminished recognition of significant problems with one's behaviors and interpersonal relationships, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Not all patients who exhibit AOMRBs meet the criteria for OUD, and conversely, not all individuals with OUD openly exhibit the most obvious aberrant behaviors.

The spectrum of behaviors is further complicated by the concept of **pseudo-addiction**. Pseudo-addiction describes drug-seeking behavior that is driven by uncontrolled or undertreated pain, rather than by the psychological compulsion characteristic of true addiction. When pain relief is inadequate, patients may engage in behaviors such as repeatedly requesting dose increases, expressing extreme focus on timing of doses, or insisting on specific medications, behaviors that might mimic addiction. However, when the underlying pain is adequately managed, these aberrant behaviors typically cease, confirming that the motivation was analgesic rather than compulsive psychoactive drug use. Clinicians must be highly adept at distinguishing between these motivations, as mislabeling pseudo-addiction as true addiction can lead to premature cessation of necessary pain relief.

When evaluating AOMRBs, clinicians utilize a hierarchical structure of concern. Behaviors considered highly predictive of an OUD or diversion include forging prescriptions, selling medications, injecting oral formulations, or obtaining opioids from non-medical sources. Behaviors considered less predictive, such as resistance to changing therapy or occasional dose escalation during a pain flare, may indicate issues with pain management or patient education rather than addiction. Comprehensive assessment, including history, physical examination, and psychological evaluation, is mandatory to move beyond the observed behavior and determine the correct underlying diagnosis, ensuring that treatment is tailored to the actual clinical need, whether that be pain optimization, behavioral modification, or specialized addiction treatment.

Classification and Typology of Aberrant Behaviors

A systematic classification of AOMRBs is crucial for standardized risk assessment and communication among healthcare providers. These behaviors can generally be grouped into three primary categories: misuse, diversion, and non-adherence. **Misuse** involves the intentional or unintentional therapeutic use of the medication in a manner other than prescribed, such as taking extra doses, combining opioids with sedatives without authorization, or using the drug to manage anxiety or sleep rather than solely for pain. **Diversion** is the act of transferring the medication to another person, whether through selling, sharing, or gifting, often indicating that the patient is receiving more medication than they require or is financially motivated.

Specific behaviors falling under these typologies include highly concerning actions such as **doctor shopping**, which is the practice of visiting multiple prescribers to obtain overlapping prescriptions, often revealed through mandated Prescription Drug Monitoring Program (PDMP) checks. Another highly suspicious behavior is the repeated loss or theft of prescriptions, particularly when these incidents occur close to the refill date. Other behaviors involve manipulation of the clinical process, such as forging written prescriptions, faking symptoms to justify higher dosages, or repeatedly resisting attempts to taper the medication despite evidence of reduced pain or significant side effects.

Conversely, some AOMRBs are indicative of simple **non-adherence** rather than addictive compulsion. These may include failing to attend monitoring appointments, being late for refills, or occasionally taking a dose slightly early. While these still require intervention (often education or reinforcement of the treatment agreement), they carry a lower predictive value for severe OUD than behaviors involving manipulation or diversion. A critical AOMRB that often confuses clinicians is hoarding--saving medication for future use or for periods when the patient anticipates pain will be worse. While sometimes interpreted as responsible self-management, hoarding can also signal attempts to stockpile for diversion or potential suicidal ideation, necessitating cautious exploration of the patient's rationale.

Risk Factors and Predictive Indicators

Identifying patients at high risk for developing AOMRBs and subsequent OUD is paramount to implementing appropriate universal precautions. Risk factors are multifaceted, spanning personal history, psychiatric comorbidities, and socio-environmental stressors. The single most powerful predictive indicator is a **personal history of substance use disorder (SUD)** involving alcohol, illicit drugs, or prescription medications. Patients with a history of remission from SUD remain at elevated risk, necessitating continuous, rigorous monitoring during opioid therapy.

Significant psychiatric comorbidities also dramatically increase risk. Patients struggling with untreated or poorly managed depression, anxiety disorders, Post-Traumatic Stress Disorder (PTSD), and especially personality disorders are more likely to engage in aberrant behaviors, often using opioids for self-medication of psychological distress rather than physical pain. A history of trauma, particularly childhood abuse, is highly correlated with both chronic pain complaints and elevated risk for developing OUD, suggesting a complex interplay between emotional and physical distress pathways. Furthermore, a **family history of SUD** among immediate relatives serves as a strong genetic and environmental predictor of vulnerability.

Socio-environmental factors contribute significantly to risk. Patients who are unemployed, socially isolated, have low socioeconomic status, or lack stable housing often face heightened stress and fewer constructive coping mechanisms, increasing the likelihood of engaging in high-risk AOMRBs. Specific pain characteristics also play a role: pain that is diffuse, poorly localized, or disproportionate to objective physical findings can sometimes be associated with increased pain catastrophizing and subsequent demands for higher opioid doses. Comprehensive risk assessment must integrate these disparate factors, moving beyond simple checklists to form a holistic picture of the patient's vulnerability profile.

Clinical Assessment and Screening Tools

The assessment of AOMRBs must be systematic and integrated into the overall pain management

process, utilizing a strategy of universal precautions applicable to all patients receiving long-term opioid therapy. Initial assessment begins with a thorough history focused not just on pain characteristics, but also on past and current substance use, family history of addiction, and co-occurring mental health conditions. This is often supplemented by validated screening instruments designed to stratify risk.

Commonly employed screening tools include the **Opioid Risk Tool (ORT)**, the **Screener and Opioid Assessment for Patients with Pain (SOAPP)**, and the **Current Opioid Misuse Measure (COMM)**. These instruments use structured questions to score risk levels (low, moderate, high), guiding the intensity of subsequent monitoring and the necessity of specialized consultation. While these tools are essential, they are not diagnostic and must be interpreted in conjunction with objective data gathered through ongoing monitoring.

Objective monitoring tools are indispensable for confirming or refuting suspected AOMRBs. These include mandatory utilization of **Prescription Drug Monitoring Programs (PDMPs)**, which provide real-time data on all controlled substances prescribed to the patient across different providers and pharmacies, effectively identifying doctor shopping. Furthermore, regular, sometimes random, **Urine Drug Testing (UDT)** is standard practice. UDT serves two primary functions: confirming the presence of the prescribed opioid and ensuring the absence of unprescribed substances (illicit drugs or unprescribed benzodiazepines), or conversely, confirming the absence of the prescribed opioid, which may indicate diversion. Consistent, thorough documentation of all assessments, monitoring results, and subsequent clinical decisions is legally and clinically mandatory.

Management Strategies and Mitigation

Management of AOMRBs follows a tiered approach based on the severity and predictability of the observed behavior. For patients identified as moderate or high risk, or following the observation of any concerning behavior, the implementation of a **Patient-Provider Opioid Treatment Agreement (or Contract)** is standard practice. These agreements formalize the expectations regarding medication use, monitoring requirements (UDT, pill counts), refill policies, and the consequences of non-adherence, thereby reinforcing boundaries and promoting accountability.

For low-level, non-adherent behaviors, the primary intervention involves education, reinforcement of the treatment contract, and potential referral for psychological or physical therapy to enhance non-opioid coping strategies. If moderate-risk behaviors (e.g., occasional early refills, minor discrepancies in UDT) are identified, the management plan typically intensifies monitoring frequency, potentially reduces the prescribed dose, and mandates integration of behavioral health support, such as cognitive behavioral therapy (CBT) for pain or mindfulness training.

When highly predictive AOMRBs (e.g., confirmed diversion, multiple positive UDTs for illicit

substances, repeated doctor shopping) are identified, a definitive shift in the treatment goal is necessary. The focus must transition away from opioid maintenance toward risk reduction and, potentially, addiction treatment. This often involves a medically supervised, gradual taper of the opioid dose, a process that must be handled sensitively to avoid abrupt withdrawal or patient abandonment. If OUD is diagnosed, referral to specialized addiction medicine services for treatment utilizing medications like buprenorphine or naltrexone becomes the standard of care, ensuring the patient receives comprehensive medical and psychosocial support.

Ethical and Legal Considerations

The management of AOMRBs is fraught with complex ethical and legal obligations. Clinicians operate under the dual mandate of beneficence (the duty to provide effective relief for suffering) and non-maleficence (the duty to prevent harm, including iatrogenic addiction or overdose). When AOMRBs are present, these duties often come into conflict, forcing difficult decisions regarding continued opioid prescribing. Legally, adherence to state and federal regulations concerning controlled substances, including mandatory PDMP checks and proper documentation, is non-negotiable.

A particularly sensitive ethical challenge arises when a clinician decides that, due to persistent high-risk AOMRBs, the therapeutic relationship must change, often involving the discontinuation of opioid prescribing. This termination of opioid therapy must be handled with extreme care to avoid the ethical violation of **patient abandonment**. The provider must ensure that the patient is not simply cut off, but rather is provided with a safe, medically supervised transition plan, including a gradual taper, referral to addiction specialists if necessary, and alternative non-opioid pain management strategies. The rationale for discontinuation must be clearly documented, focusing on the safety risk posed by the aberrant behavior rather than a punitive response.

Furthermore, the legal implications of diversion are significant. While clinicians are primarily responsible for patient care, they also have a societal responsibility to prevent controlled substances from entering the illicit market. Reporting confirmed diversion activities may be legally required in some jurisdictions, placing the provider in a position where patient confidentiality must be balanced against public safety concerns. Ultimately, the ethical standard requires transparent communication with the patient at every stage, ensuring they understand the reasons for monitoring and the potential consequences of non-adherence, thereby preserving the dignity of the patient while upholding the standards of responsible medical practice.