Repositório ISCTE-IUL

Deposited in *Repositório ISCTE-IUL*:
2026-03-04

Deposited version:
Accepted Version

Peer-review status of attached file:
Peer-reviewed

Citation for published item:
De Bonte, L., Vanbavinckhove, J., Goubert, L., Baert, F., Pype, P., Schelfout, S....Ceuterick, M. (2026). Individuals with chronic pain using opioids: Challenging treatment choices, shared decision-makers, or risk-makers? A critical discourse analysis of Belgian policy documents. Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine. N/A

Further information on publisher's website:
10.1177/13634593251377102

Publisher's copyright statement:
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Individuals with Chronic Pain Using Opioids: Challenging Treatment Choices, Shared Decision-Makers, or Risk-Makers? A Critical Discourse Analysis of Belgian Policy Documents

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ABSTRACT

Chronic pain, defined as pain persisting for more than three months, affects one in four Belgian adults. Treating chronic pain comprises challenges for patients and clinicians as the term encompasses diverse conditions such as fibromyalgia, migraine, and long-term pain without a known biomedical cause. Additionally, growing evidence highlights the limited efficacy of opioids in managing chronic non-cancer pain. This has prompted critical policy changes in pain management, including shifts away from opioid use. This study explores how Belgian policy documents depict patients, healthcare providers, and therapeutic relationships within the context of opioid use in the treatment of chronic non-cancer pain. A critical discourse analysis of 32 Belgian Dutch-language policy documents was performed using Fairclough's framework. This approach examines how language in texts reflects and shapes social power dynamics and ideologies, and allows us to gain insight into the policy discourses surrounding opioid use for chronic pain.

Based on our analysis, we suggest that written policy texts about the use of opioids to manage chronic pain are constructed through the deployment of three discourses: a medical authority discourse, a patient empowerment discourse, and a high-risk medication discourse. While all discourses are rooted in the biopsychosocial pain model, they prioritize different aspects of chronic pain management. While the medical authority discourse emphasizes the decision-making role of physicians, the patient empowerment discourse shifts attention to patients' experiences and preferences. Lastly, the high-risk medication discourse underscores opioids' addictive potential. These discourses reflect varying perspectives on chronic pain management and have different implications for clinical practice. The findings offer valuable insights into how Belgian policy documents discursively construct or challenge therapeutic relationships and stigma.

KEYWORDS

Chronic pain; opioid medication; healthcare policy; Belgium; critical discourse analysis; stigma

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INTRODUCTION

One in four Belgian adults is affected by chronic pain, often referred to as "the silent epidemic" (Beckers and Steveniers, 2023; Drieskens and Charafeddine, 2019). Pain is defined as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (IASP, Raja et al., 2020, p. 2). To highlight pain's multidimensional nature, Williams and Craig (2016) proposed a definition that includes sensory, emotional, cognitive, and social components.

Chronic pain, defined as pain lasting longer than three months, encompasses a wide range of conditions (Cohen et al., 2021). In the ICD-10, it is classified as either primary (i.e., without an identifiable underlying medical condition, like fibromyalgia) or secondary (e.g., linked to identifiable underlying medical causes, like injury) (Treede et al., 2019). Its varied causes make treating chronic pain challenging for both clinicians and patients (Raffaeli et al., 2021).

Opioids, which act on opioid receptors to relieve pain, remain a contested treatment option. They include both legal (e.g., morphine) and illegal substances (e.g., heroin), though legal substances can also be produced and used illicitly (e.g., fentanyl) (McCradden et al., 2019). Whereas opioids were prescribed sparingly for chronic non-cancer pain before the 1980s, shifts in policy and pharmaceutical marketing led to increased opioid prescribing (Tompkins et al., 2017). The American Pain Society's "Pain as the 5th Vital Sign" campaign and the WHO analgesic ladder contributed to this expansion, broadening opioid use beyond its original scope (Yang et al., 2020; Scher et al., 2018).

In North America, the surge in opioid prescriptions resulted in a public health crisis marked by morbidity and mortality, often described as the opioid epidemic (McCradden et al., 2019). This crisis fueled moral panic and stigma related to opioids, portraying opioid use as a dangerous or criminal act (Buchman et al., 2017). Stigma involves labeling human differences as socially significant, stereotyping (i.e., attributing negative traits to those labeled), reinforcing a divide between 'us' and 'them,' and ultimately leading to discrimination, status loss, and reduced life opportunities for the stigmatized (Link and Phelan, 2001).

Moreover, evidence suggests that opioids have limited effectiveness in managing chronic non-cancer pain (Reinecke et al., 2015), prompting a reassessment of opioid policies. This shift is reflected in the Centers for Disease Control and Prevention (CDC) 2016 guidelines, which advocate for non-opioid therapy for chronic non-cancer pain (Volkow et al., 2018; Dowell et al., 2016). Following the release of these guidelines, Goldstick et al. (2021) report a decline in opioid prescriptions in the U.S.

However, heightened regulatory scrutiny has also led to so-called 'opioid pharmacovigilance' or even 'opiophobia,' referring to a reluctance or fear to prescribe or use opioid medications, even when medically appropriate (Knight et al., 2017). In this context, policy guidelines and the language they employ may inadvertently reinforce stigma toward patients who rely on opioids for chronic pain (Moore et al., 2020; Cheetham et al., 2022).

Qualitative studies from the U.S. and Canada report that individuals using opioids for chronic pain often feel labeled as "addicts" or "drug seeking," and experience discrimination in healthcare settings (Dassieu et al., 2021; Antoniou et al., 2019). Restrictive prescribing policies have also been linked to emotional distress among prescribers, erosion of trust in patient-provider relationships, and patients' feelings of invalidation and powerlessness (McCradden et al., 2019; Benintendi et al., 2021; Kennedy et al., 2017).

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Despite growing attention to opioid stigma, little research has examined how this stigma is produced through policy language. Most studies focus on outcomes or effectiveness (Howard et al., 2018; Schuler et al., 2020; Goldstick et al., 2021), with few analyzing how policy texts construct opioid use, the patient-provider relationship, and stigma. One exception is a critical discourse analysis of a Canadian training program, which showed that “addressing risk” was framed in a moralized manner (Sud et al., 2022).

To address this gap, this study applies critical discourse analysis (CDA) to investigate how Dutch-language policy documents in Belgium construct discourses on opioid use for chronic pain. Specifically, it explores: (1) prevailing policy discourses, (2) representations of patients and healthcare providers, and (3) the sociocultural implications of these discourses, including their impact on clinical recommendations and stigma. This study uses Fairclough’s (1992) CDA approach, a method for studying how language reflects and reinforces power dynamics. This framework links micro-level textual features with broader structures, making it well-suited for studying how discourse shapes power relations in healthcare.

Belgium presents a compelling case for studying opioid policies in chronic pain management due to its high opioid prescription rates and unique healthcare context. Belgium ranks third in Europe in opioid consumption, with opioid use increasing by 88% between 2006 and 2017 before slightly declining after 2020 (Meeus et al., 2024). The country has a universal healthcare system in which patients can access secondary care without a general practitioner (GP) referral; however, referrals from GPs or specialists are typically required to enter multidisciplinary pain clinics. National chronic pain management policies are shaped by international guidelines, such as those from the CDC, which are adapted to the Belgian context.

MATERIAL AND METHODS

2.1. Data collection

This study analyzes 32 Belgian Dutch-language policy documents using a CDA approach. These documents, issued between 2014 and 2024, originate from four key actor categories: (1) federal agencies and institutes, (2) expertise networks and centers, (3) professional associations for physicians, and (4) peer-reviewed journals. They comprise healthcare policy, clinical practice, and professional education regarding the prescription and provision of opioid medication for chronic non-cancer pain in Flanders, the northern Dutch-speaking region of Belgium. Opioid use in Belgium varies regionally, with Flanders having a lower percentage of users but a generally higher Defined Daily Dose (DDD) per patient than the national average (Meeus et al., 2024). This pattern suggests that fewer individuals in Flanders use opioids, but at higher doses, which possibly indicates a more selective prescribing practice.

The data were collected in two rounds conducted by two researchers (JV and LDB). In the first round, online searches using keywords, like “chronic pain,” “opioids”, and “guideline”, were combined with a survey distributed to over 150 clinical settings (October 2023-January 2024). The survey assessed which opioid-related prescribing, dispensing, and tapering policies are used, and how they are implemented, communicated, and monitored (see supplementary material for details).

A total of 55 settings participated in the survey, including Flemish pain clinics within university hospitals (N=2) and non-university hospitals (N=7), as well as pharmacies (N=32), community health centers (N=5), doctors’ offices (N=2), and drug treatment services (N=7). Most respondents relied on national guidelines, while international guidelines were primarily consulted by physicians in multidisciplinary pain centers. The survey also uncovered one additional local policy document, which was added to the dataset.

The second round occurred during analysis to identify additional documents cited in the first dataset. As a result, 20 articles from journals and websites of GP-oriented organizations were included (Wets et al., 2023). This iterative process aligns with Fairclough’s (1992) concepts of interdiscursivity and intertextuality, which describe how texts and discourses draw upon, reference, echo, and respond to each other (Wets et al., 2025). In total, 32 Belgian Dutch-language policy documents were included (see supplementary material for details).

2.2. Data Analysis: Critical Discourse Analysis as methodological framework

Fairclough’s (1992) dialectical-relational approach to CDA conceptualizes discourse as a mode of action that people use to act upon the world and others. Building on insights from linguistics, political science, and sociology, Fairclough (1995) describes a dialectic relationship between discourse and social structure in which discourse is both shaped by structural factors (e.g., globalization) and shapes social structures (e.g., norms). This study applied Fairclough’s three-level framework, using the qualitative software program NVivo (version 14).

The first level of Fairclough’s framework, **text analysis**, examines vocabulary, grammar, and structure to explore how language constructs meaning and reflects social roles and knowledge. At this stage, the main researcher (LDB) thoroughly familiarized herself with the material through repeated readings of the policy documents. Initial coding focused on both semantic and latent content and led to the development of a preliminary code tree. Annotations highlighted notable linguistic features and captured what was being articulated in the texts.

The second level, **discursive practice**, looks at how texts are produced, shared, and interpreted. This includes, for example, how an author's background influences the way information is presented. This analysis phase focused on the identification of discourses and discursive devices (i.e., language tools like metaphors that shape meaning and influence interpretation) (Wood and Kroger, 2000). The initial codes were revised and nested (e.g., "risk factors for problematic behavior" under "high-risk medication discourse") to reflect identified discourses more precisely.

The third level, **discourse as social practice**, explores how language reflects and reinforces power structures and ideologies (Fairclough, 1992). Stigma was used as a guiding sensitizing concept, given the known social consequences of opioid-related policy discourse for individuals with chronic pain (Antoniou et al., 2019). Findings were situated within health literature and refined through consultations with researchers in medicine, psychology, and sociology, and individual sessions with discourse analysts experienced in Fairclough's approach.

2.3. Positionality and reflexivity

This analysis was carried out by a junior researcher (LDB) with a background in criminology and sociology, under the guidance of a senior researcher (MC) specializing in sociological qualitative research and textual analyses of stigma. Because the researcher was not trained as a clinician, she could view the subject from an external standpoint. This, in combination with a social constructionist standpoint and a focus on stigma, heightened attention to the social implications of language within policy documents. This standpoint enabled the main researcher to view policy documents not as neutral reflections of reality, but as discursive constructions that shape how opioid use and those involved in it are understood and acted upon.

Reflexivity was ensured through iterative feedback from an interdisciplinary research team. Preliminary findings were presented to a group consisting of clinical psychologists, a sociologist, and a GP. The GP's questions about the intentionality behind discursive choices shaped how the findings were interpreted and framed. In a later phase, discussions with pain specialists and a pharmacist added further clinical insights. Transparency was ensured by clearly documenting the selection process for policy documents, the iterative data collection strategy, and the systematic coding procedures in NVivo.

RESULTS

Using CDA, we suggest that written policy texts about the use of opioids to manage chronic pain are constructed through the deployment of three discourses: (1) a medical authority discourse, (2) a patient empowerment discourse, and (3) a high-risk medication discourse. While all texts are grounded in the biopsychosocial model of pain, each discourse reflects a distinct perspective on chronic pain treatment. More specifically, they differ in how healthcare providers and patients are positioned in the treatment process.

We present the core messages, textual and discursive practices, and power dynamics implied by each discourse. This structure is informed by Fairclough's (1992) three-dimensional framework: 'core messages' and 'power dynamics' reflect aspects of the social practice level, while 'textual and discursive practices' capture features of both the text and discursive practice levels. The following table provides an overview of the three policy discourses:

Table 1. Overview of the constructed discourses

Discourses	**Medical authority**	**Patient empowerment**	**High-risk medication**
Linguistic and discursive characteristics	Use of archaic words (e.g., opioid abusus, toxicomania), hedging, critical tone, the use of neutral language, figures or tables, and non-personal nouns A high degree of intertextuality, particularly with international biomedical studies and guidelines ("best evidence")	Use of the term "patient(s)" as a noun or object, directly addressing the reader, use of the terms "health literacy", "self-management", "pain/peer education", example cases and fictional prescriber-patient interactions, "together with patient(s)"	Worst case scenario, presenting a substantial amount of statistical data, opioid use as a "spreading epidemic", use of the terms "risk (physicians)" "problematic use/behavior", risk factors presented in bullet points, syllogism, nominalization
Source context	Frequently used in policy reports issued by federal agencies and expertise centers	In educational material for prescribing physicians issued by an expertise center	In articles from scientific journals by and for healthcare providers
Ideology	Emphasis on biomedical aspects of pain, authoritarian patient-provider relationship	Patient-centered care	Risk management in healthcare
Power dynamics	The agency of healthcare providers stressed	Equal position for physician and patient, focus on shared decision-making	Limited agency attributed to healthcare providers and patients

3.1. The medical authority discourse

Core messages of the discourse. A medical authority discourse emphasizes the biomedical aspects of pain care and prioritizes the decision-making agency of medical professionals. Authors employing this discourse focus primarily on biological causes of pain and biomedical interventions, as these align with

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the expertise of medical professionals. While the biopsychosocial model is acknowledged, the biomedical perspective takes precedence, and psychosocial dimensions are often positioned as secondary considerations.

In this discourse, the biopsychosocial model is framed as a toolbox comprising both pharmaceutical (e.g., prescription of opioids or non-steroidal anti-inflammatory drugs) and non-pharmaceutical interventions (e.g., manual therapy, pain education) that a physician can recommend or use to treat chronic pain. This discourse places physicians in a position of authority over the patients, and they are portrayed as gatekeepers to obtaining opioids. Beyond reinforcing physicians' authority over patients, this discourse also upholds the dominance of medicine over other disciplines essential for pain management, such as psychology, nursing, and physiotherapy.

Textual and discursive practices. This discourse is most common in the studied texts, particularly in policy reports of expertise centers and professional associations. It is characterized by a high level of intertextuality with international studies and guidelines. Within this discourse, biomedical research is viewed as the most robust form of evidence for supporting biomedical recommendations, while “expert opinion” is regarded as weaker and more subjective. Specifically, authors refer to studies that directly investigate biological mechanisms or clinical outcomes, such as Randomized Controlled Trials (RCTs) and meta-analyses. Although RCTs and meta-analyses are also esteemed in other disciplines, in these texts they are cited predominantly when they pertain to biomedical findings. Additionally, international guidelines from Anglo-Saxon countries are frequently cited and described in detail.

A critical tone is adopted to scrutinize aspects of studies and guidelines, such as study design, target population, and research limitations. In Quote 1, this tone is evident in the emphasis on the lack of high-quality evidence (“few high-quality RCTs”), the use of hedging (i.e., a linguistic device that softens claims or expresses uncertainty, “generally effective”), and the rejection of treatment based on these limitations. Such a tone is typical in academic and medical writing, where critical evaluation of evidence is crucial. In this example, it conveys objectivity and legitimizes the authors’ recommendations.

> *"**There are few high-quality RCTs** on the use of dietary supplements in the treatment of chronic pain. **Dietary interventions were generally effective** when combined with breathing exercises and acupuncture. **However, the evidence is limited**. Therefore, this form of treatment was not included in this recommendation."* (Quote 1, T10, policy report, p.30)

Neutral language, figures or tables, and passive verb forms are employed as techniques for constructing facts, grounded in the post-positivist assumption that reality can be uncovered and presented objectively and without bias. In quote 2, the expression “the study showed” serves as a distancing device to create an impression of objectivity. By attributing the claim to the study itself rather than to its authors, this discursive device obscures agency and presents the findings as self-evident (Wood and Kroger, 2000).

Furthermore, the use of passive voice in “patients who were treated pragmatically” obscures the possible subjectivity of the involved healthcare providers by omitting these actors from the sentence. These strategies, whether consciously applied or simply adopted as part of conventional scientific and policy writing, work together to present the information as factual and authoritative, thereby legitimizing the organization’s perspective on the ineffectiveness of opioids for long-term chronic pain management.

> *“In an American study conducted over 12 months with 240 chronic osteoarthritis and back pain **patients who were treated pragmatically** (individual goals, treat-to-target approach), the effects on function and pain were compared between an opioid strategy and a non-opioid*

> *strategy.* ***The study showed*** *that an opioid strategy for chronic pain patients is not beneficial in the long term: over a period of 3 to 12 months, opioids are no more effective than non-opioids in improving function or pain, and they lead to significantly more adverse effects."* (Quote 2, T5, policy report, p.1)

In addition, hedging strategies are employed as a discursive device to express uncertainty regarding social and psychological interventions. Cognitive behavioral therapy is the only psychological intervention mentioned multiple times (T4, T10, T1, and T23), labeled as "a weak recommendation based on low to very low evidence" using the GRADE system (T10). Social interventions, like social work, are mentioned just once (T4). Phrases like "appears to influence" or "can be considered" in quote 3 suggest a cautious stance toward non-biomedical interventions. This hesitancy may stem not only from perceived evidence limitations but also from professional power struggles between disciplines. Given this text was issued by the Belgian Centre for Pharmacotherapeutic Information - an organization that provides evidence-based guidance on medicines - its perspective is primarily rooted in biomedical expertise. This may contribute to the undervaluing of non-medical approaches.

> *"Social Interventions*
> *Social Work*
> *If chronic stress due to psychosocial problems* ***appears to influence*** *the pain, guidance from a social worker* ***can be considered****.*
> *Occupational Physician*
> *If the work situation causes or maintains the pain, or if the complaints impact the work situation, an occupational physician can be involved."*
> (Quote 3, T4, educational material, p. 17)

Power dynamics implied by the discourse. In this discourse, the decision-making power of physicians in prescribing opioids for chronic non-cancer pain is emphasized, as they are expected to weigh the costs and benefits when initiating or evaluating opioid treatment. Based on thorough monitoring of pain relief and functional improvement, they should determine whether to continue prescribing opioids. Patient agency is minimized, assuming that patients are inclined to continue opioid treatment regardless of the circumstances. Quote 4 underscores the physician's agency by portraying patients as "challenging treatment choices." This is reinforced by a metaphor likening the decision to prescribe either gabapentinoids or opioids to choosing between "the plague and cholera".

> *"By definition, patients suffering from chronic non-cancer pain are synonymous with very* ***challenging treatment choices*** *or, at the very least, serious concerns for both primary and secondary healthcare providers. [...] NICE highlights the risk of dependence and tolerance associated with opioids as well as with gabapentinoids—****let's avoid having to choose between the plague and the cholera."*** (Quote 4, T22, article, p.1-2)

The use of archaic language or medical jargon can reinforce the power imbalance inherent to an authoritarian view of healthcare. For instance, the terms "opioid abusus" and "toxicomania" appear in quotes 5 and 6, despite "abuse" and "addiction" being more commonly used, even within clinical settings. While this choice of language may partly reflect the intended audience, it also contributes to a medicalized framing that detaches opioid use from its psychosocial and behavioral context. In doing so, the text not only reinforces the provider's authority over patients but also plays into professional power struggles within healthcare. By medicalizing opioid use in this way, the discourse may serve to uphold the dominance of medical expertise while sidelining perspectives from other disciplines, such as psychology or social work.

> *"How should the prevention, detection, and treatment of **opioid abusus** be best organized?"* (Quote 5, T28, policy report, p.136)

> *"The doctor must avoid prescribing opioids solely at the patient's request. The doctor must be fully aware that these substances are prone to fraud and can therefore be used in a medically irresponsible manner (for maintaining **toxicomania**, trafficking, and recreational use)."* (Quote 6, T26, advisory text, p. 1)

3.2. The patient empowerment discourse

Core messages of the discourse. Contrary to the previous discourse, the patient empowerment discourse emphasizes the central role of patients in decisions regarding opioid use for chronic pain management. The studied policy documents shift the focus to patients' perspectives based on the assumption that chronic pain is a complex condition, often inadequately explained by biomedical knowledge alone. Consequently, patients are granted a higher-level agency in the development of a multidisciplinary treatment plan. This also creates space for non-medical interventions, recognizing the role of psychological, social, and lifestyle factors in pain management.

Textual and discursive practices. Unlike the medical authority discourse, which prioritizes the biomedical aspects of the biopsychosocial model, this discourse places greater emphasis on the psychosocial dimensions. It particularly highlights the principle that a patient's personal experience is a key source of clinical information. The term "patient(s)" is frequently used as either a noun to describe their experiences with opioid treatment (quote 7) or an object in a sentence to highlight the need to consider their preferences in healthcare decisions (quote 8). Authors use these discursive devices to integrate the patient's perspective into opioid prescription policies for chronic pain management.

> *"Often, the general practitioner is the first healthcare provider to discuss with **the patient** that it is important to reduce or stop the opioids. **Patients** may feel that they have not been provided with the proper care or that they have been wronged."* (Quote 7, T12, article, p. 2)

> *"It is also crucial to provide sufficient information to **the patient** about their condition and treatment (psychoeducation), to involve **the patient** in their treatment, and to make a number of clear agreements about the use of opioids (Bateman, 2015)."* (Quote 8, T30, educational material, p. 27)

Authors who use the patient empowerment discourse highlight the importance of patients' feelings, preferences, and backgrounds to foster empathy and trust. In quote 9, they point out the fear patients may experience when tapering off opioids by directly addressing the reader and comparing healthcare providers' emotional responses to patients' feelings. The informative and compassionate tone in this quote, from an educational online guide for prescribers, encourages the careful tapering of opioid treatments. A patient-centered approach may thus be employed to facilitate opioid abstinence, thereby still focusing on treatment goals that are desired by policymakers.

> *"But what about the pain, the reason for which the opioids were prescribed? Patients are afraid of having more pain again if the opioid dosage is reduced. Maybe you, as a doctor or pharmacist, are also afraid of this. But will someone who tapers off opioids have more pain again?"* (Quote 9, T2, educational material, p. 7)

Chronic pain is a complex phenomenon and the extent to which it is understood in medicine varies. In this discourse, emphasis is placed on patients' personal experiences, coping strategies, and motivations. Terms like "self-management", "health literacy", and "pain/peer education" in three policy reports (T10,

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T18, and T28) suggest a patient-centered approach aimed at encouraging patients to take an active role in their treatment. Furthermore, the studied educational materials promote the principles of motivational interviewing through example cases and fictional prescriber-patient interactions (quote 10), including 'ideal' prescriber responses. This strategy allows the reader to visualize interactions with patients and create awareness about their experiences and feelings, thereby reducing distance and fostering empathy.

> *"DOCTOR: I see here that you've had back pain for a long time. How is it currently?*
> *PATIENT: It's really bad right now, but the opioids help with the pain.*
> *DOCTOR: I'm sorry to hear that it's so severe. Can you tell me more about how the pain affects your daily life?*
> *PATIENT: Yes, I often can't go to work. And at home, I just sit on the couch or lie in bed. Because of the pain, I can't do anything. I think I need more opioids, like my previous doctor gave me when I was in pain.*
> *DOCTOR: That really sounds like an unpleasant situation; I'm sorry to hear that. Because of the pain, you're often not at work and just stay at home."* (Quote 10, T3, educational material, p. 7)

Power dynamics implied by the discourse. Shared decision-making is considered crucial within this discourse. While the term "shared decision-making" is rarely used within the studied texts, the principles are endorsed by the addition of "together with the patient(s)" in discussions of decision-making or treatment goal setting (quote 11). This approach not only grants patients agency in shaping their treatment plans but also reinforces the relational nature of medical encounters**.** Patients are positioned as active participants with rights in their pain management, as seen in policy documents that emphasize the "right to effective pain relief" (quote 12). This discourse also broadens the physician's role from a prescriber to a partner in a complex, patient-centered process where communication and the clinical relationship are essential.

> *"When starting opioids, a clear and realistic treatment goal is* ***set together with the patient:*** *the expected reduction in pain, the improvement in overall functioning, and the anticipated side effects."* (Quote 11, T13, article, p. 3)

> *"Both for acute and chronic pain, every patient has* ***the right to effective pain relief****. When acetaminophen and NSAIDs have insufficient effect, the use of opioids can be considered. […]"* (Quote 12, T19, article, p. 1)

3.3. The high-risk medication discourse

Core messages in the discourse. The high-risk medication discourse focuses on the psychoactive properties of opioid substances. This discourse is predominantly constructed in articles published in scientific journals by and for healthcare providers. Authors employing this discourse highlight opioids' addictive potential and harmful societal effects, particularly in countries like the U.S. Consequently, this discourse opposes opioid use in the treatment of chronic pain. By disapproving of opioids as a pharmaceutical intervention to treat chronic pain, the agency of both healthcare providers and patients is restricted.

Textual and discursive practices. This discourse assumes that opioid use in Belgium risks becoming a crisis, which is substantiated by a syllogism (i.e., a form of deductive reasoning that derives a conclusion from two affirmed premises). In the following quotes, the authors draw parallels between the rising levels of opioid use in Belgium and the opioid epidemic in the U.S. From this comparison, they conclude that the increase in opioid prescriptions in Belgium creates "risks" and "potential problems" for patients with chronic pain. However, the statistics do not clarify the medical reasons for the prescriptions, so it remains unclear how many are for chronic pain.

> ***Major premise****: "Internationally, there is especially a lot of attention on the 'opioid crisis' in the United States. A years-long increasing use of opioids has had a number of unintended negative consequences: a large group of people shows problematic opioid use (abuse, addiction) and the number of deaths by overdose has increased very strongly."* (Quote 13, T4, educational material, p. 1)
>
> ***Minor premise****: "From 2006 to 2017, the total number of patients who consumed at least one of these opioids increased by 88% to 1,104,485 insured individuals, or 10% of all Belgians."* (Quote 14, T4, educational material, p. 1)
>
> *"**Conclusion***
> *Many Belgians use opioids. [...] Besides the risks of these medications in terms of dependence or overdose, there are many other potential problems that can arise with chronic use. And this while opioids will often provide little benefit to the patient with chronic pain."* (Quote 15, T4, educational material, p. 5)

In this discourse, terms like "problematic use" or "problematic behavior" serve as umbrella categories for actions such as "abuse", "misuse", "addiction", "overdose", and "pill shopping". Risk factors are linked to the different dimensions of the biopsychosocial model and grouped into three categories: substance (e.g., the use of strong, rapid-onset opioids), person (e.g., male sex or a history of dependence), and environment (e.g., past judicial problems) (T4, T11, T28, T30, and T31). However, by including judicial issues as an environmental risk factor, the texts may inadvertently conflate opioid-related health problems with criminal behavior and reinforce punitive policies rather than health-centered solutions. In the studied texts, risk factors are often presented in bullet points.

Prescriber-related risks are addressed in three texts (T4, T11, and T28), with authors noting that these issues often arise from a GP's lack of experience with prescribing opioids. One text (T11) introduces the term "risk physicians" from the American Medical Association to describe doctors who improperly prescribe opioid medication due to outdated knowledge, being deceived, dishonesty, or impairment. Nominalization (i.e., a discursive device where a noun replaces a process) can conceal and remove the responsibility of the involved actors. This is evident in quote 16, a text issued by a professional organization for GPs, where the term "bribability" is used instead of explicitly stating that "the doctor allows themselves to be bribed by patients." While this choice minimizes blame for prescribers, it may contribute to the stigmatization of patients.

> *"[...] The third (dishonest) is **the bribability**. In these rare cases, disciplinary and legal sanctions are imposed. The fourth (disabled) is **the unfitness**. This pertains to doctors with personal medical or psychiatric problems, such as drug dependency or a personality disorder, which prevents them from adjusting their attitude towards the patient who misuses medications."* (Quote 16, T11, policy report, p. 7)

This discourse presents U.S. interventions for monitoring and limiting opioid use, like electronic medical records, opioid treatment contracts, or screening tools, as best practices for Belgium. In quote 17, from an article published by a professional association for GPs, the authors emphasize a U.S. project's effectiveness by presenting a substantial amount of statistical data. This framing may serve as a form of validation for their stance, appealing to the authority of scientific evidence. However, unlike the medical authority discourse, the authors omit details on the project's context, outcome measurement, and limitations. Their concluding argument includes a metaphor that depicts opioid use as "a spreading epidemic" to be averted by Belgian GPs.

A policy text issued by a national institute explicitly criticizes this rhetoric by warning for adopting North American interventions without considering differences in political and societal contexts (see quote 18). This interaction is an example of dialogic intertextuality and reveals a tension between the desire for rapid adoption of proven interventions and the need for contextually appropriate policy development.

> *"[...] The result was a 30% reduction in high-dose opioid prescriptions, a 98% reduction in prescriptions for more than 200 pills, a 90% reduction in the combination of opioids with benzodiazepines and carisoprodol, [...] That these interventions have been effective is something we can already learn from in Belgium, so that* ***we can together build a dam against the spreading epidemic****."* (Quote 17, T11, policy report, p. 4)

> *"[...]* ***This risks the pendulum swinging towards overregulation and restriction*** *of the use of opioid analgesics, and that patients will be denied a powerful painkiller that is effective under proper medical supervision."* (Quote 18, T28, policy report, p. 48)

Power dynamics implied by the discourse. By opposing opioids for chronic pain treatment, the high-risk medication discourse restricts the agency of both prescribers and patients. The incorrect application of the WHO pain ladder to chronic pain is often referenced to explain unjustified prescribing behavior (see quote 19). In this quote, the authors use a worst-case scenario, a discursive device highlighting a situation's most negative outcome, to create a sense of urgency. In this case, the authors may use it to bolster their statement and urge readers to limit opioid prescriptions to patients with chronic pain. Additionally, they also give power to other healthcare professionals who are involved in pain management. By recommending non-pharmacological therapies and interdisciplinary care (involving professionals from psychology, physiotherapy, etc.), they distribute authority across different professionals in the pain care process.

> *"****The WHO pain ladder has a specific area of application****: cancer pain. The management of chronic non-cancer pain is not part of it. [...]* ***To prevent an opioid epidemic****, it is absolutely necessary to set the threshold high: only in combination with non-pharmacological therapy and non-opioid medication, and only if the potential benefits outweigh the expected risks."* (Quote 19, T13, article, p. 4)

This discourse promotes interventions aimed at monitoring and controlling patients, often inspired by U.S. strategies to prevent problematic or undesirable behavior. In quote 20, the authors, all healthcare professionals, propose the "Opioid Risk Tool" to calculate an addiction risk score based on ten factors, including personal and family drug use. This tool reduces patients to a numerical value indicating their risk level and the need for monitoring.

> *"In this case, it concerns acute, postoperative pain, where the need to provide painkillers for more than a week is rare. Does Tom have a risk profile for addiction? The MFO provides a risk scale for this:* ***the Opioid Risk Tool*** *(Table 1). This is a tool to help assess the risk. However, this tool is not flawless, as it can be unreliable in patients who have experience with opioid use."* (Quote 20, T13, article, p. 2)

DISCUSSION

This study identified three distinct discourses surrounding opioid use and chronic pain in Belgian policy documents, each with implications for stigma. Firstly, the **medical authority discourse** is grounded in the biomedical model, which posits a linear relationship between tissue damage, the experience of pain, and an exemption from normal social responsibilities (what Parsons (1951) referred to as 'the sick role') (Perugino et al., 2022).

The sick role grants individuals certain rights, such as relief from daily responsibilities and exemption from blame, while also imposing duties, including seeking treatment, accepting medical authority, and striving for recovery (Parsons, 1979; Parsons, 1951). It positions patients as passive recipients of care, with little to no role in treatment decision-making. The biomedical model thus prioritizes interventions that are selected, administered, and monitored by medical professionals (Johnson et al., 2022).

Although several texts referenced the biopsychosocial model, their focus remained largely on biomedical dimensions of pain. This discourse emphasized the decision-making agency of healthcare providers and prioritized interventions targeting the biological causes of pain. Linguistically, this was reflected in medical jargon, archaic language, and the framing of patients as "challenging treatment choices". Healthcare providers were thus positioned as gatekeepers to both the legitimacy of pain and the sick role, thereby reinforcing power imbalances in the patient-provider relationship. Moreover, this medicalized framing of opioid use also upholds the dominance of medical expertise over other disciplines, such as psychology or social work.

The failure of the biomedical model to explain pain without a clear biomedical cause (e.g., tissue damage) or its persistence beyond the expected healing time contributes to the stigma surrounding chronic pain (Van Alboom et al., 2021; Van Alboom et al., 2023; De Ruddere and Craig, 2016). Research showed that patients with chronic pain face stigmatization as they are unable to meet the societal and medical expectations of recovery stemming from an understanding of pain based on acute pain experiences (Schipke, 2021; Glenton, 2003).

Although the analyzed texts were void of explicit manifestations of stigma, the medical authority discourse paid little attention to the perspective of patients and implied that they always favor continued opioid treatment regardless of its effectiveness. There is an underlying suggestion in these texts that patients seek opioid treatment to maintain access to the sick role, which legitimizes their pain experiences and potentially destigmatizes their condition. This aligns with research on benzodiazepine use, which shows that patients want to conform to prescribers' expectations of 'the legitimate patient' to avoid stigmatization (Ceuterick et al., 2023; Van Ngoc et al., 2024).

Secondly, the **high-risk medication discourse** intensified the stigma related to chronic pain by highlighting opioids' addictive potential and the urgency of opioid tapering. While Belgium does not currently face an opioid epidemic as seen in North America, this discourse assumed that opioid use poses a potential crisis for the country. Aligned with Beck (1992; 2009) and Giddens' (1990; 1991) work on risk, the opioid crisis is depicted as a risk created by modern healthcare systems, which aimed to solve the problem of pain but ended up creating new risks related to opioid misuse.

Drawing on Beck and Giddens' work, Lupton (2023) described how risk discourses shape how we perceive and deal with risks. More specifically, she categorized actors as risk-preventers (subjects responsive to risk and engaging in prevention) or risk-makers (sources of risk requiring observation, regulation, and discipline). In our study, authors employing the high-risk medication discourse proposed interventions that frame patients as risk-makers. For example, the "Opioid Risk Tool" allows GPs to identify which patients are sources of risk.

Simultaneously, healthcare providers are encouraged to self-regulate their prescribing to avoid blame or sanctions. Terms such as "risk physicians" in policy texts create institutional pressure to conform to risk-averse practices and prioritize harm avoidance over other concerns. Physicians navigate competing pressures: alleviating pain while avoiding opioid prescriptions to minimize societal harm. This limits their agency and promotes defensive medicine, where risk avoidance overshadows patient-centered care (Eftekhari et al., 2023).

As a result, prescribers themselves may be stigmatized as risk-makers alongside patients. Medical associations may use this framing to distance themselves from 'misbehaving' members and protect the profession's reputation. Notably, this discourse was primarily constructed in texts authored by healthcare providers, reinforcing peer stigma - an insider process where professionals stigmatize colleagues for undesirable behaviors, like prescribing opioids for chronic pain (Madden et al., 2021).

Thirdly, patient-centered care has been found to improve patient-provider relations and reduce the stigma associated with different health conditions, including chronic pain (Phelan et al., 2023; Tseng et al., 2024; Becker, 2020). In our study, the **patient empowerment discourse** introduced a framework for patient-centered care, an approach introduced during the 1980s and 1990s to challenge the hierarchical power dynamics in healthcare (Weberg and Davidson, 2017). This discourse centered on patients' perspectives and granted them greater agency in shaping multidisciplinary treatment plans. By encouraging healthcare professionals to view patients as active partners rather than passive recipients of care, this discourse may reduce stigma in the patient-provider relationship.

However, authors who used the patient empowerment discourse often shifted quickly to the medical authority discourse in the analyzed policy documents. 'Discourse-switching' is a discursive practice that refers to shifting between different ways of communicating about a topic. It illustrates how language changes based on power dynamics and communicative goals. In the studied documents, authors highlight patient empowerment in introductory sections but adopt the medical authority discourse to provide clinical guidelines. As most documents are orientation materials for prescribers, the patient-centered sections in the introduction may be overlooked. This potentially guides prescribers toward a more directive role and limits the actual implementation of shared decision-making.

Additionally, despite the call for interdisciplinary treatment of patients with chronic pain, the attention to psychological or social interventions was limited in the studied documents. This gap may not only reflect the authors' lack of expertise in these areas but also reinforce existing power hierarchies within healthcare, where biomedical perspectives tend to dominate (De Ruddere and Craig, 2016). By incorporating a broader range of expertise and emphasizing patient-centered approaches, future policies can mitigate stigma and promote more comprehensive care for patients with chronic pain.

Involving professionals from diverse disciplines and patient representatives is essential for developing stigma-sensitive, patient-centered policies. Yet, stigma itself can hinder meaningful patient participation, especially when patients are framed as 'passive recipients of care' or 'risk-makers'. Previous research reported that the language used by policymakers significantly influences public support for patient involvement (Cheetham et al., 2022). Therefore, we recommend adopting person-centered, non-stigmatizing language and creating protocols to facilitate patient involvement in policy design.

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LIMITATIONS

This study analyzed Belgian Dutch-language policy documents published in the last decade by scientific and professional healthcare organizations. Consequently, the findings are specific to this dataset and cannot be generalized to other materials or contexts. This study did not evaluate the accuracy of the policy guidelines but focused on the discursive devices used in policy construction to reinforce or challenge dominant ideologies. Further research should investigate policy discourses on chronic pain and opioid use in broader settings, including their impact on public opinion, clinical communication, and stigma.

We applied Fairclough's (1992) three-level framework to CDA to explore how texts reproduce or challenge dominant ideologies within broader societal contexts. However, the framework lacks standardized procedures and depends heavily on researchers' interpretative skills, raising the risk of overinterpretation. Reflexivity was therefore central to our approach, as outlined in the methods section. The data were also limited to publicly available policy documents, except for one internal document that was obtained through one of the respondents of the survey. As a result, we did not attain insight into the discursive practices related to the development, distribution, and reception of these documents. Furthermore, some locally used policy documents were not shared with us and were not published online, which further constrained the scope of our analysis.

CONCLUSION

The findings of this CDA offer valuable insights into the discourses about opioid use and chronic pain management in Belgian policy documents. Based on Fairclough's dialectical-relational approach (1992), three discourses that reflect different healthcare perspectives upon opioid use were identified. The medical authority discourse emphasized the biomedical aspects of pain care and prioritized the decision-making agency of healthcare providers. The experiences and agency of patients were centered in the patient empowerment discourse, while the high-risk medication discourse highlighted opioids' addictive potential and harmful effects. This analysis allowed us to gain an understanding of how stigma is constructed in discourses favoring the medical authority of healthcare professionals, as patients living with chronic pain and using opioids do not fit the sick role. Furthermore, risk discourses can perpetuate this stigma by promoting avoidance of harm (e.g., addiction) over other concerns (e.g., quality of life, pain relief). Discourses based on patient-centered care and patient empowerment seem central to deconstructing the stigma of chronic pain and opioid use. Therefore, policymakers should consistently apply a multidisciplinary, patient-centered perspective on chronic pain management during policy development.

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