PAINWEEK

Minimizing Pills and Maximizing Skills: Achieving Successful Opioid Cessation in Chronic Pain

Jennifer Hah, MD, MS

Disclosures

- Nothing to disclose

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Learning Objectives

- Recognize the core concepts of motivational interviewing (MI), understand the evidence-based applicability of MI to opioid tapering, and to identify opportunities for further training.
- Develop an interdisciplinary approach to opioid tapering by incorporating pain psychology principles into patient education, and referring patients to appropriate specialists to optimize outcomes.
- Construct an interdisciplinary approach to opioid tapering with knowledge of existing alternative resources when an interdisciplinary team is not readily available.

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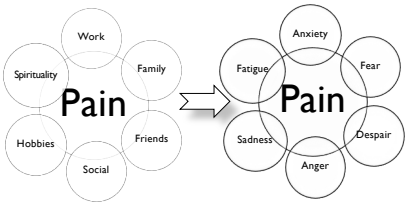
Impact of Pain



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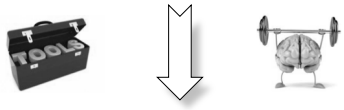
Role of Pain Psychology

- Teach patients nonmedication coping skills
- Target emotional suffering and negative impact on function
- Provide opioid education and taper support



SELF-MANAGEMENT

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What is Pain Psychology

- Assessment
- Motivational interviewing
- Cognitive-behavioral approaches
- Self-regulation and relaxation training
- Mindfulness and acceptance based approaches
- Pain-specific concepts
  - Neuroscience education
  - Active vs passive coping
  - **Pain catastrophizing, pain anxiety**
  - Pain self-efficacy
  - Other tools beyond the scope of today's talk (time based pacing, sleep strategies, pleasant events, communication skills, etc)

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Talking Points for Patients

- All pain has a psychological component
- Seeing a psychologist does not mean pain is not real
- Nervous system: physical ⟷ psychological pain
- Psychosocial factors are strong predictors of pain outcomes
- Pain psychologists focus on function and quality of life

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Long-Term Opiate Use

- Disrupted sleep quality
- Decreased sex hormones
- Addiction
- Death from overdose
- Reduces pain threshold
- **Mood disturbances**

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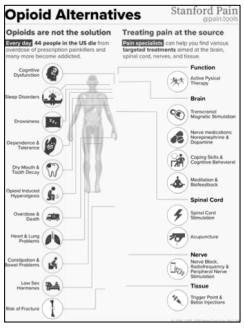

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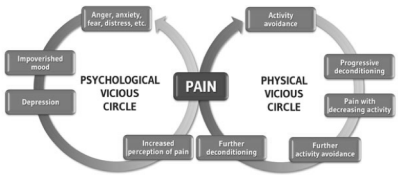
Cycle of Chronic Pain



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Psychology & Opioids

Treatment targets and bidirectional relationship

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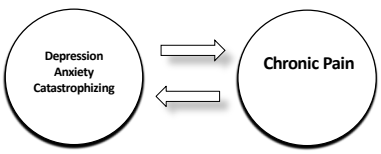
Mental Health & Chronic Pain



Prescription Opioid use among Adults with Mental Health Disorders in the United States-PubMed- NCBI. https://ncbi.nlm.nih.gov/pubmed/28720623.

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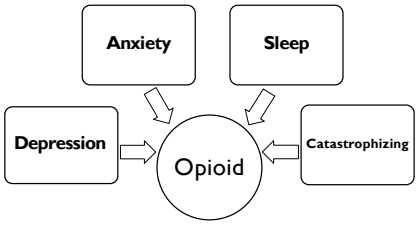
Mental Health & Opioids



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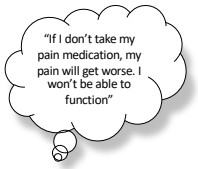
mison, Serraillier, Michna. Assessment and treatment of abuse risk in opioid prescribing for chronic pain. Pain Res Treatment 2011; 2011:1-13.

Pain catastrophizing: persistent negative cognitive and emotional responses to actual or anticipated pain

Pain anxiety: fear in response to pain and anxiety in the context of reducing opioids



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Pain Catastrophizing & Opioids

Catastrophizing ⇒ Pain ⇒ Opioids

- **Primes the nervous system for pain**
- **Increased pain intensity**
- **Opioid misuse**
- **Persistent opiate use 10 y/r follow-up**

Edwards, Wasan, Michna, Greenbaum, Ross, Jamison. Elevated pain sensitivity in chronic pain patients at risk for opioid misuse. J Pain 2011; 12:953-63.
Sullivan, Thorn, Keefe, Martin, Bradley, etal. Theoretical perspectives on the relation between catastrophizing and pain. Clin J Pain; 17:52-64.
Quartana, Campbell, Edwards. Pain catastrophizing: A critical review. Exp Rev Neurother 2009; 745-58.

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Evidence Based Therapies

Treatments for opioid tapering

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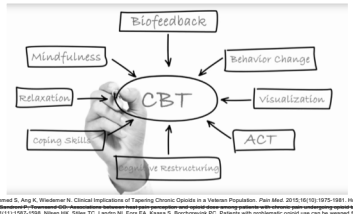
Treatments



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Hooten P, Ahmed S, Ang K, Wiedemer N. Clinical Implications of Tapering Chronic Opioids in a Veteran Population. *Pain Med.* 2015;16(10):1975-1981. Hooten WM, Townsend CO, Sletten D, Bruce BK. Association between pain, perception and opioid dose among patients with chronic pain undergoing opioid tapering. *Pain Med.* 2010;11(11):1587-1598. Nilsen HK, Stiles TC, Landro NI, Fors EA, Kaasa S, Borchgrevink PC. Patients with problematic opioid use can be weaned from codeine without pain escalation. *Acta Anaesthesiol Scand.* 2010;54(5):571-579.

What is Motivational Interviewing (MI)

- **Client-centered**, collaborative, goal-oriented **style of communication**
- Elicits behavior change by helping patients explore and resolve **ambivalence** within an atmosphere of **acceptance** and **compassion**
- **Goal:** facilitate internally motivated choices

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Human Motivation

- People generally resist being coerced
- Everybody is motivated for something
- *The point is not **whether** they're motivated or not, but **what** they're motivated for*
- Motivation for change is:
  - Malleable
  - Fluctuates over time and across situation
  - A product of interaction between people, not within one person

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

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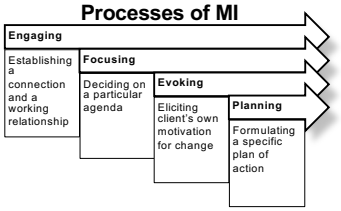
Processes of MI



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Motivational Interviewing

Tools

- Open questions
- Affirmations
- Reflections
- Summary

Change Talk

- Desire—"I want to…"
- Ability—"I can…"
- Reasons—"I would probably feel better if…"
- Need—"I have to…"

- Commitment—"I will…"
- Activation—"I'm ready to…"
- Taking steps—"This week I started…"

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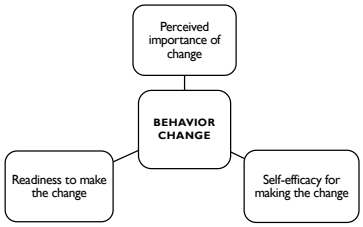
Motivational Model



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MI-Based Interventions

- **Eliciting:**
  - History related to pain, opioid therapy, and related difficulties
  - Change talk related to tapering
- **Education:** Dose-related health risks, opioid-induced hyperalgesia
- **Identifying:** Barriers to tapering, problem-solving ways to overcome these, and commitment to change

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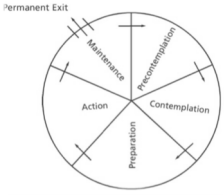
Stages of Change

- Determine the patient's current stage of change
- Intervention should match current stage of change
- Goal for visit is to move patient one stage forward



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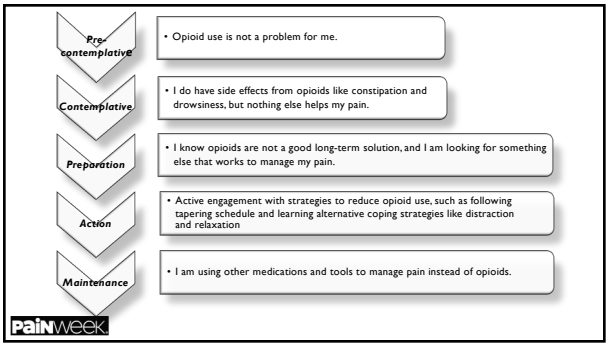
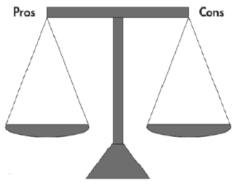


Tipping the Balance

Clinician's tasks:

- Explore both positive and negative prospects of life with and without the proposed changes
- Help patient understand discrepancy between current behavior and long-term goals



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MI Example

Next Step:
Assess the stage of change

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MI Example

Assessment: **Pre-contemplation**

- Our goal: move to contemplation stage

Pros/Cons: Illicit from patient, provide psychoeducation if patient is open to it

How does behavior fit with long term goals?

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MI Example (OARS)

- Open-ended questions: *What are some of the benefits of Norco? What are the drawbacks?*
- Affirmations: *Living with pain is difficult, and you've tried several ways of coping with it.*
- Reflective listening: *You've tried not taking Norco but then you have more pain, and feel nauseous too.*
- Summary: *Norco takes the edge off, but you still have pain. When you run out early, you know it's painful and you feel sick. There are some risks to long term opioid use, but nothing you've tried has been as effective. You've tried PT and a few other medications, but there are some medications you haven't tried yet.*

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MI Example

- Patient moved from **pre-contemplative** to **contemplative stage**
- Can take several sessions
- Include psychoeducation when appropriate
- Provide tools (stress management, ACT, CBT, mindfulness, self regulation, etc)
- Ongoing assessment of stage of change and barriers to success including depression, anxiety, fear, and/or trauma history

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Responding to Relapse

- Normalize relapse process
- Praise accomplishments
- Discuss what can be learned from relapse
- Reframe relapse as being one step closer to maintenance
- **Relapse prevention plan**
  - Review original motivations for tapering
  - Identify potential triggers for relapse
  - Plan in advance how you will cope
  - Identify support systems for returning to taper

"What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?"

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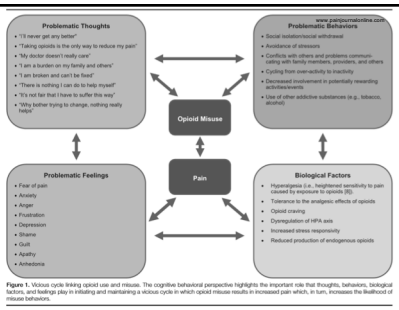

Figure 1. Vicious cycle linking opioid use and misuse. The cognitive behavioral perspective highlights the important role that thoughts, behaviors, biological factors, and feelings play in initiating and maintaining a vicious cycle in which opioid misuse results in increased pain which, in turn, increases the likelihood of misuse behaviors.

VanDenburg, Vilardaga, & Keefe. Opioid Therapy and persistent pain: can cognitive behavioral therapy help? Pain 2018; 159: 411-415.

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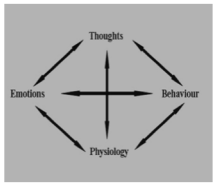
Cognitive Behavioral Therapy



Hofmann, S. G., et al. (2012). "The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses." Cognit Ther Res 36(5): 427-440.

- Evidence-based
- Symptom-focused
- Time-limited
- Validated and widely used
- Employs collaborative approach
- Targets **unhelpful beliefs and behaviors**
- Increases self-efficacy and coping skills
- Gradual and cumulative benefits

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Automatic Negative Thoughts

ANTs

- Very common
- Occur automatically
- Often happen at night
- Often inaccurate and always unhelpful
- Increase hyperarousal → increase pain

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CBT Techniques

Cognitive behavioral treatment techniques used for opioid use and substance use disorders.

Treatment component	Treatment overview	Treatment target	References
Cognitive restructuring	Help patients identify and challenge problematic thoughts that may trigger opioid use and replace these thoughts with more adaptive coping thoughts.	Problematic thoughts that may trigger opioid use (eg, "Taking opioid medication is the only way to reduce my pain").	25
Contingency management	Issue patients tangible reinforcers (eg, vouchers that have monetary value) when abstinence is demonstrated. Withhold such reinforcers from patients when opioid use is detected.	Reinforcing effects of opioids that may trigger opioid use (eg, analgesic effects).	26,27
Relapse prevention	Help patients understand, anticipate, prevent, and cope with relapse episodes (eg, a failure to abstain from opioid use).	Problematic opioid use following a period of improvement or after the initiation of decreased use.	23
Skill training	Train patients in cognitive and behavioral strategies for addressing factors likely to lead to drug misuse, for example, training interpersonal skills (eg, communication skills and assertive exercises), emotion regulation skills (eg, distress tolerance), and/or behavioral skills (eg, behavioral activation to enhance involvement in pleasant and meaningful goals including increased social interaction).	Coping skill deficits, including interpersonal difficulties, emotion dysregulation, activity level, and goal-setting deficits.	20,24
Mindfulness	Foster non-judgmental, non-reactive awareness of the present moment, including thoughts, feelings, and body sensations.	Automatic, mindless patterns of reacting to experiences and events that contribute to misuse of opioids.	4,38
Acceptance	Increase patients' willingness to experience (but not be directed by) thoughts, feelings, and sensations that may act as cues for opioid use, and increase engagement in valued activities.	Thoughts, feelings, and sensations that may trigger opioid misuse.	13,30
Motivational interviewing	Guiding patients to explore the possibility of change and confidence in their ability to make such changes in opioid use.	Ambivalence about need for or desire to change/ reduce opioid use, lack of self-efficacy beliefs about ability to change.	3

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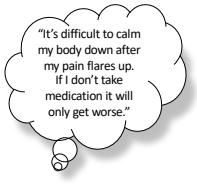
Unhelpful Thoughts

Pain catastrophizing:
persistent negative cognitive and emotional responses to actual or anticipated pain

Pain anxiety:
fear in response to pain and anxiety about experiencing pain



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Common Unhelpful Thinking Styles

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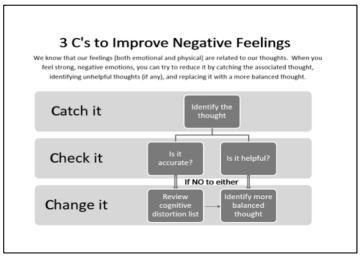
Catch It, Check It, Change It



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CBT for Pain Example

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CBT Strategies

- Self regulation strategies
- Goal setting
- Exercise
- Socialization
- Pleasant activities
- Time based pacing
- Distraction
- Communication training
- Sleep hygiene or CBT-I
- Coping prevention plan

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Physiological Stress Response

- Stress can be a clear **pain trigger**
- Some patients **cope with stress** by taking opioids
- Stress affects **sleep and mood**
- Pain is a stressor and acts as an ALARM, and activating our "fight or flight" response can worsen pain
- Pain and stress affect similar areas in the brain
- **Reducing our stress response** can help prevent, alleviate, and cope with pain, anxiety associated with pain and medication tapering

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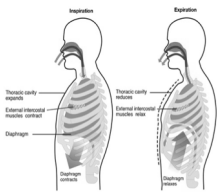
Diaphragmatic Breathing

- Gateway to ANS
- HARM alarm system
- Pain, anxiety, stress, cravings
- Practice daily practice
  - (5-10 min, BID)



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Self-Regulation

- Progressive muscle relaxation
- Diaphragmatic breathing
- Guided Imagery
- Body scan
- Meditation
- Mindfulness
- Prayer
- Acupuncture
- Biofeedback
- Stretching
- Foam rolling
- Tai Chi
- Yoga
- Feldenkrais

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Tool Box for Opioid Tapering

- Neuroscience and opioid education
- Self regulation strategies
- Goal setting
- Cognitive restructuring
- Behavioral activation
- Pleasant activities
- Time based pacing
- Communication training
- Sleep hygiene or CBT-I
- Coping prevention plan
- Values based living, defusion and mindfulness

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Resources

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Resources

- Search the national Substance Abuse and Mental Health Services Administration (SAMHSA) **Opioid Treatment Program Directory:** http://dpt2.samhsa.gov/treatment/directory.aspx
- **Buprenorphine** prescribers: https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- Additional **MI** training: http://www.motivationalinterviewing.org/
- Mindfulness Based Stress Reduction: palousemindfulness.com
- Find an MBSR instructor/program near you: http://www.umassmed.edu/cfm/stress-reduction/find-an-mbsr-program/
- Retrain Pain Foundation: https://www.retrainpain.org/

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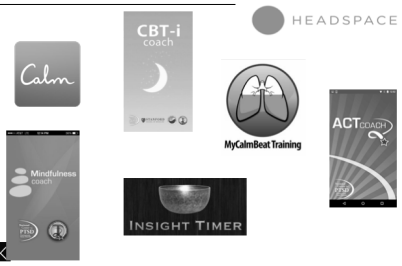
APPs



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Self-Help Books

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Summary of Strategies

MI

- ✓Assess stage of change
- ✓OARS
- ✓Pros/Cons
- ✓Change talk
- ✓Support active coping
- ✓Ongoing re-assessment of stages of change
- ✓Reframe relapse

Tapering Strategies

- ✓Psychoeducation about long term opioid use and provide alternatives
- ✓Tapering schedule
- ✓Medication and behavioral management of withdrawal and cravings
- ✓Relaxation training
- ✓Cognitive-behavioral approaches
- ✓Mindfulness and acceptance-based approaches

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