



Painful Conversations Made Easier: Talking Patients Out of Wanting Opioids



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The Family Medicine Foundation of West Virginia is proud to partner with the Claude Worthington Benedum Foundation on the development of a new and improved chronic pain treatment model which will be effective and affordable in clinical settings of all types.

One profound health issue challenging health care providers across the country is the treatment of chronic pain. The challenge of chronic pain has become further complicated by the rise in prescription drug abuse. This abuse has reached epidemic levels, and the Family Medicine Foundation of West Virginia and the Benedum Foundation are determined to provide a best practice model of care for chronic pain. The project also aims to help combat the prescription drug epidemic by reducing the number of chronic opioid users.

This new chronic pain model includes:

- An algorithm for evidence-based chronic pain care which will be replicable in most, if not all, medical settings where chronic pain patients are treated
- Development of practical and efficient training tailored for providers of various types and training levels in the implementation of the chronic pain model in diverse health care settings
- Practical support for health care providers to help treat their patients effectively and efficiently

Current Participation



Claude Worthington Benedum Foundation

For more information on the Claude Worthington Benedum Foundation, please visit www.benedum.org.



Family Medicine Foundation of West Virginia

For more information on the Family Medicine Foundation of West Virginia and this project, please visit www.fmfww.org.

3 OBJECTIVES

Attendees will be able to:

1. Recognize conditions contributing to pain and opioid misuse
2. Identify evidence-based (ie non-opioid) treatments for pain
3. Describe communication strategies useful in patient discussions about avoiding opioid therapy for chronic pain

CDC RE OPIOIDS IN WOMEN

- Women: More likely to have chronic pain, be prescribed an opioid, higher doses, longer duration (Frieden, CDC, 2013)
- 48,000 women died from OD 1999-2010
- 18 women died per day in 2010
- 4X more OD on meds than heroin+cocaine
- Become dependent quicker and doctor shop
- Screen; use drug monitoring; no BZD+opioid

PATIENT CHARACTERISTICS OF OPIOID VS. NSAID DRUG
MANAGEMENT IN CHRONIC LOW BACK PAIN
(Breckenridge & Clark, Journal of Pain, 2003)

	Adjusted Odds Ratio
Depression	7.88
Personality Disorder	18.81
Substance Abuse Hx	4.72

WHAT ARE OPIOIDS TREATING?

1. Unrecognized substance use
 - 1/3 of chronic pain patients develop opioid dependence
 - 46% of patients with chronic pain have history of illicit drug use
2. Unrecognized comorbid psychiatric diagnoses
 - Depression, anxiety, substance use, PTSD result in expression of distress
3. System failures (opioids cheaper than PT)
4. Lack of access to resources for behavioral health

WHO/WHAT WILL OPIOID BENEFIT?

Patient?

- Patient distress
- Pain behaviors
- Opioid use disorder
- Withdrawal symptoms
- Pressure from family, dealers, debtors
- Anxiety, depression, other psychiatric disorders

Staff?

- Distress re patient's condition/situation
- De facto pain treatment in light of limited resources (PT, OT, Pain Clinic, etc)
- Desire for patient satisfaction
- "Clinical inertia re ineffective medication use" -*Erin Krebs, MD, APS 2015*

IF CONFRONTED WITH DEMAND FOR OPIOID THERAPY...

1) Evaluate and diagnose patient.

What am I **really** treating?

2) What does the evidence indicate re treatment?

3) If I start opioids, how will I stop?

4) What additional problems could it cause?

5) How do I deliver compassionate care?

ASSESS FOR PSYCHIATRIC DISORDERS

- Anxiety/Panic
GAD-7
- PTSD/History of Sexual or Physical Abuse
- Somatic Symptom Disorders (IBS, Fibro)
- Personality Factors
 - Borderline=impulsivity
 - Dependent=vulnerable to partner
 - Sociopaths=possible criminal intent

We often treat distress with opioids

Depression



- Benefit less from opioids
- Increased risk for misuse
- Depression precedes pain
- Treating depression may improve pain
- 30-60% of depressed patients have chronic pain

THE PATIENT WITH OPIOID DEPENDENCE:

- Consequences

- Use despite harm (Sedated, irritable, anxious, pain increase)

- Compulsive use

- Lost meds, withdrawal Ss, urgent calls for refills)

- Craving

Preoccupation with use (No relief/not try other treatments, misses appointments unless opioid expected, focused on med)

Savage, 2002, Clin J Pain

CONTRAINDICATIONS

- History of substance use
- Depression and anxiety
- Severe COPD or Obesity
- Sleep apnea w/o CPAP
- Impulse control problems
- Suicidal/homicidal
- Poor social support/Abusers
- Poor employment history
- Thought disorder
- Significant cognitive deficits



CHRONIC PAIN AND OPIOIDS?

- Lack of evidence for effectiveness or safety, especially for high dose
- Rebound pain/hyperalgesia *PCSS-0 2014*
- Withdrawal syndromes look like pain escalation
- Increase problems after 90 days +/- or 100mg
- NO evidence of benefit for
 - Axial low back pain, Fibromyalgia, Headache
 - (90% of painful conditions)

PRINCIPLES FOR ACUTE PAIN

- Change the conversation to function not pain
- Medical reassurance is the single most effective intervention
- Avoid delays in care and expect improvement
- Consult pain specialist/psychologist early
- Structured approach. Explain rules/stick to them.
- Active PT or structured physical activity
- Address fear and catastrophizing
- No opiates beyond 6 weeks

Dan Doyle. Compassionate Care for Chronic Pain. Nov 5, 2010

EVIDENCE-BASED TREATMENT OF CHRONIC PAIN

- Listen carefully to patient. Do Physical Exam
- Measurement tools: PHQ-9, GAD-7, PCS, ORT
- Primary Treatments:
 - Motivation/Activation/Self-Efficacy
 - Counseling for Harm reduction via lifestyle interventions (sleep, physical activity, nutrition, smoking cessation, weight loss)
 - Reassurance by primary care provider is most effective intervention

EVIDENCE-BASED TREATMENT OF CHRONIC PAIN

- Secondary Treatments:
 - Low risk analgesics
 - Headache, LBP, Fibromyalgia: TCA or SNRI
 - Neuropathy: anticonvulsants, SNRI
 - Rehabilitation, Physical Therapy, Exercise
 - Meditation and Relaxation; Acupuncture
 - Cognitive Behavior Therapy (*Behavior rewires biology*)

Ballantyne, 2012

PHYSICIAN-DIRECTED LIFESTYLE THERAPY FOR CHRONIC PAIN

- Daily Activity/ Exercise
- Yoga/ Tai Chi
- Stress Reduction Meditation,
Breathing
- Diet control
- Results in improved pain
tolerance, reduced
hyperalgesia, better
memory, reduced distress



Katherine Brushnell, APS, 2015

WRITE BEHAVIORAL SCRIPTS

Written orders can motivate patients

In Spain, half the patients in a group of 4000 were given general advice to exercise, while the other half got actual prescriptions to do so. Six months later, according to a report in the *Archives of Internal Medicine*, the patients who received the prescriptions were more physically active than those who hadn't.

Problem: Pain

- 1) Walk 5 minutes daily
- 2) Listen to CD 2X per day
- 3) Tai Chi or other stretching 10 minutes AM and PM
- 4) Pleasant activity 20 minutes

HOW TO SAY NO

- The Three “E”s

Empathize

Evaluate

Educate

-When patient is demanding antibiotics for a virus, MRI, or an opioid...

-a) A Primary Experience and b) A Longing

- *Adapted from Dike Drummond, MD:
thehappy.md.com*

EMPATHIZE: THEY LONG FOR YOUR EMPATHY

- a) Primary Experience: Your Patient is Suffering
- b) Longing: They want to be heard.

“Wow, that sounds terrible.”

“You sound miserable, how are you holding up?”

“I hate it when that happens, you must be very frustrated.”

“You poor thing, I am so sorry this is happening to you.”

EVALUATE: TO ALLEVIATE FEAR

Primary Experience: worrying that “something serious” is going on.

Longing: Doctor’s opinion so they get treated appropriately for what is REALLY going on.

Your job: Evaluate. Focused history , focused exam, well reasoned diagnosis.

If opioid use disorder, patient fears being without their most significant other: Opioids. This fear is realistic, and will need to be addressed without taking it personally.

EDUCATE: ADDRESS INCORRECT ASSUMPTION

Primary Experience: thinking they know the solution and you are the source.

Longing: for something they can do to simply feel better

You have a condition called chronic pain, which is manageable but unlikely to completely go away.

Here's what you can do to take care of yourself and improve your functioning.

Opioid pain medications will not improve your quality of life and will make your pain worse over time.

Opioid pain medications can cause constipation, sexual dysfunction, irritability, foggy thinking, and can cause you to stop breathing and die.

There are some other medications and treatments that are helpful in getting your life back despite having some level of pain..

THE UNIVERSAL UPSET PATIENT PROTOCOL

2-4 minutes vs 20 if you ignore or are defensive

- 1) *“You look really upset.”*
- 2) *“Tell me about it.”*
- 3) *“I’m so sorry this is happening to you.”*
- 4) *“What would you like me to do to help you?”*
- 5) *“Here’s what I’d like us to do next.”*
- 6) *“Thank you so much for sharing your feelings with me. It’s really important that we understand each other. Thank you.”*

- <http://www.thehappy.md.com/blog/bid/290399/Doctor-Patient-Communication-The-Universal-Upset-Patient-Protocol>

DISPLAY EMPATHY AND DE-ESCALATE ANGER

- Listen without interrupting with eye contact
 - Keep calm, breathe, go to balcony
 - Use “I will” not “you should” statements
- Acknowledge: Feel Felt Found
 - I can understand how you would feel _____
 - I/most people would have felt _____
 - We have found this to be best to do _____
- Address issue or Admit if can't fix
- Allow time to calm down
- Attend to comfort and relationship

DEALING WITH PATIENT'S PARTNER

- Listen, Acknowledge, Address
- “I can see you are upset. What happened?”
- “I would feel frustrated, too, if ...”
- “I will address this situation by...”
- “What would make you feel better about this now? We can do ____”
- Calm speech and non-verbals (not turn back on partner, keep distance, open stance)
- Ok to focus on patient and ask to leave, involve by ask to keep list of questions or observations

TALKING ABOUT PATIENTS: IMPLYING POSITIVE INTENT

Negative/Passive

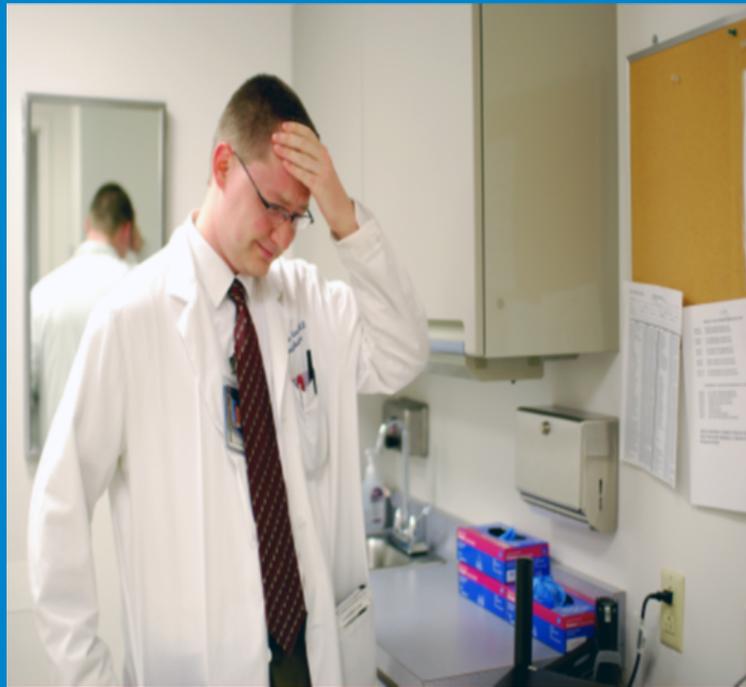
- *Complains of*
- *Suffers from*
- *Refused to take*
- *Didn't show for appointment*
- *Was non-compliant*
- *Arrived late*

Positive/Active

- *Came for help with*
- *Struggles with*
- *Decided against*
- *Unable to be here*
- *Not see the value of*
- *Was determined not to miss*

Adapted from Larry Mauksch, U
of M, 2015

PHYSICIAN, HEAL THYSELF



- Practice self-compassion and self-care
- Nutrition, exercise, sleep, faith, family, friends
- Balance schedule for tough/easy patients
- Mindfulness
- Tarzan rule

RESOURCES FOR PATIENT EDUCATION

- <http://www.supportprop.org/educational/index.html>
and go to bottom of page. There is an 11-minute video to show patients.
- Two new videos “Understanding Pain in Under 5 Minutes” to show patients:
“Brainman Chooses”
<https://www.youtube.com/watch?v=IEde49emlL4>
“Brainman Stops his Opioids”
<https://www.youtube.com/watch?v=AACIGAG1V6Q&list=UUrq65tnl1SSFUtbZy6vNYVw>
- www.fibroguide.com