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# Behavioral Management During Opioid Tapering

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# Introduction and Disclosure



Hello  
my name is



- ▣ The views expressed here are my own and do not necessarily reflect those of VHA, the national pain management office, or mental health services

# Objectives

- ▣ Review important behavioral and psychological considerations when preparing for opioid tapering
- ▣ Discuss the most common challenges experienced during opioid tapering
- ▣ Examine strategies to optimize cessation engagement and success

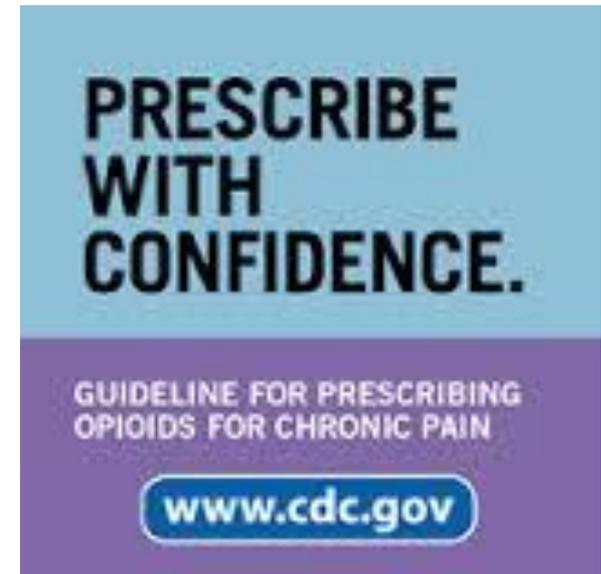
# Focus on Opioid Safety

- ▣ Increased attention on opioids due to dramatic increase in prescribing and opioid-related deaths<sup>1</sup>
- ▣ Prescriptions have increased by more than 300% since 1999
- ▣ In 2013 more than 16,000 people died in the US from opioid-related overdose death
- ▣ Since 2009, leading cause of accidental death is drug overdose versus motor vehicle accidents



# Center for Disease Control Guidelines

- ▣ CDC released March 18, 2016<sup>1</sup>
- ▣ Addresses:
  - ▣ When to initiate or continue opioids for chronic pain
  - ▣ Opioid selection, dosage, duration, follow-up, and discontinuation
  - ▣ Assessing risk and addressing harms of opioid use
- ▣ New VA/DoD chronic opioid therapy guidelines being drafted currently



# VA's Opioid Safety Initiative (OSI)



- ▣ Action plan to improve patient safety and quality of pain management specific to opioid therapy
- ▣ Focus on prescriber education and training
- ▣ Aligned with national private and public initiatives to reduce the number of patient on high dose opioids, overdoses, and deaths

# Why We Taper

- ❑ Adverse effects
- ❑ Diminishing/absent analgesia
- ❑ Opioid use disorder, misuse, diversion
- ❑ **Reduced/inadequate functioning and quality of life**
- ❑ **Lack of evidence for chronic opioid therapy benefits; significant evidence of chronic opioid risks**



## But When We Taper...

- ❑ At times, tapering is not/has not been handled in the most clinically sensitive/therapeutic manner
  - ❑ Providers may struggle with directives, not know how to manage patient reactions
  - ❑ Behavioral health and other staff may feel underprepared to address challenges
  - ❑ Information/explanation provided to patients may be insufficient

# Clinical Characteristics

# Patient Presentation

- ❑ Evidence suggests that up to 43% of those with opioid use disorders have co-occurring psychiatric disorders<sup>2,3</sup>
- ❑ Some studies indicate that affective disorders are associated with lower pain tolerance, higher medical noncompliance, and higher rates of hospitalization
- ❑ Although contrary to clinical guidelines, those with mental health disorders such as PTSD and substance use history are **more likely to be prescribed opioids and at higher doses**

# Psychiatric and Medical Comorbidities

## ▣ Psychiatric

- ▣ Depression
- ▣ Anxiety
- ▣ Mood swings
- ▣ Anger/irritability/low frustration tolerance
- ▣ Concentration/attention/memory complaints
- ▣ Feelings of paranoia or panic
- ▣ Substance use disorder history

## ▣ Medical

- ▣ Diabetes
- ▣ Hypertension
- ▣ Hyperlipidemia
- ▣ Sleep apnea
- ▣ Asthma/COPD
- ▣ MI
- ▣ GERD

# Psychosocial Issues

- ▣ They also frequently have various psychosocial issues that negatively impact daily life
  - ▣ Marital/relationship problems
  - ▣ Absenteeism/poor performance at work or school
  - ▣ Financial stress
  - ▣ Social isolation/loss of friendships
  - ▣ Lack of recreational/leisure activities
  - ▣ Role struggles (e.g., in parenting, caring for home)

# Healthcare Frustrations

- ❑ Suspicious of healthcare providers and angry at system because of perceived injustices
  - ❑ Iatrogenic escalation
    - ❑ “We” prescribed these medications and now they are being treated as if they have a drug problem
  - ❑ May feel they are being treated/labeled unfairly
  - ❑ Often feel misunderstood/not “heard”
  - ❑ Want pain to be “fixed” and have not received appropriate pain education or a reasonable long-term management plan

# Evaluation

- ▣ Good pain-focused clinical interview is critical
  - ▣ Focus on FUNCTION
  - ▣ Detailed information about current life
    - ▣ “What does a typical day look like for you?”
  - ▣ Substance Use – present and past
    - ▣ Opioids may have replaced previously used substances
    - ▣ Concurrent use of benzodiazepines
    - ▣ Want sense of “chemical coper” status

# Evaluation

- ▣ History of self-harm behaviors, current suicidal ideation, hospitalizations
  - ▣ This population is at higher risk
- ▣ Resources
  - ▣ If they have relied heavily on opioids, they may have tendency to passively cope/lack strong active coping skills
  - ▣ May not have been offered options for developing skills

# Considerations in Approach

- MUST develop rapport early – provide empathy and normalize feelings while not colluding
- Evaluate the whole person and identify relevant issues in *how* tapering should be discussed – where to focus
- Impact motivation for change and facilitate readiness
  - Understanding all functional domains helps shape dialogue with insight into what the individual values
- Consider how this might help even if patient is opposed

# Challenges and Strategies

# The Challenge

- ❑ Often the patients who need opioid tapering the most are the ones who want it the least
- ❑ They may be focused on medical solutions/a “fix”
- ❑ Many have not fully acknowledged and/or may not be fully aware of how opioids:
  - ❑ Have impacted their lives in negative ways
  - ❑ Are not beneficial to functioning
- ❑ Others may not care because at least it “takes the edge off”



## The Fear Factor

- ▣ The single greatest challenge in initiating a taper is **FEAR**
- ▣ Even when ineffective or minimally effective, it may be difficult to imagine life without opioids
- ▣ Often, it is a fear of the unknown
  - ▣ Maybe the hell you know is better than the one you don't
  - ▣ What if...



## The Fear Factor

- ▣ The clinical interaction is characterized by a sense of desperation and focus on/concern about accessing opioids on an ongoing basis
- ▣ Those accustomed to having/using opioids may experience some level of concern – from passing worry to outright panic
- ▣ Even in the absence of functional benefit, familiarity breeds a psychological dependence rooted in fear

# The Fear Factor

- ▣ *“What are you most worried about?”*
  - ▣ Increased pain
  - ▣ Withdrawal symptoms
  - ▣ Not having an alternative
  - ▣ “Needing” them and not being able to get them
- ▣ Communicate directly and respond to fears

## Increased Pain: Approach

- ▣ Overall patients do not report increased pain and report improved functioning<sup>4-7</sup> and even decreased pain levels<sup>8-10</sup>
- ▣ Educate about the need for a “big picture” strategy for which medication is one small piece
  - ▣ When it comes to chronic pain, there are no pain “killers”!
- ▣ Remind: no opioids does not mean no meds, just safer/wiser med choices

# Increased Pain: Approach

- “What does this drug do for you?”
  - Important for patient to reflect on this...usually **“reduce my pain and improve my functioning”** is not the answer
- May derive pleasure/euphoria but many do not now
- More likely to “take the edge off”
  - Often times the numbing element is the most powerful – the softening of life, including psychiatric symptoms, that may not be managed in any other way
    - Acknowledge this and propose changed approach



## Withdrawal: Approach

- ▣ Physiological symptoms
  - ▣ Explain that since body is physically dependent/“used to” opioids, withdrawal symptoms during tapering may occur – high level of individual variability
    - ▣ This does not mean they are a drug abuser
  - ▣ Provide specific examples to reduce concern
    - ▣ For example, may feel a bit restless or have more difficulty sleeping; employ relaxation techniques

# Withdrawal: Approach

- ❑ Critical to provide clear and explicit information regarding what the patient can expect during tapering
- ❑ Be realistic
  - ❑ Differentiate between discomfort and pain
    - ❑ Uncomfortable feeling does not mean an opioid is needed or even that there is an increase in pain
    - ❑ May be helpful to compare to craving/“need” for a cigarette – normalize experience while reducing use of substance

# Withdrawal: Approach

- ❑ Slow outpatient taper should mitigate significant withdrawal; if inpatient/other then withdrawal will be addressed with meds PRN
- ❑ May also be helpful to explain difference between stopping “cold turkey” and *tapering*
- ❑ Physical or emotional discomfort does not constitute an emergency – plan for this

# No Alternatives: Approach

- ▣ Offer treatment options – options are good!
  - ▣ Pain rehabilitation program
  - ▣ CBT-CP/ACT-CP
  - ▣ Other rehab options
    - ▣ Aquatic therapy, physical therapy, rec therapy
- ▣ Many safe analgesic options that may not have been trialed or trialed appropriately
- ▣ Developing a concrete plan with the patient is very comforting and works well to quell fears/panic

## No Alternatives: Approach

- ❑ Patients may refuse treatment which is their decision and right – responsibility is to make choices/recommendations available
- ❑ Not obligated to provide opioids; obligated to provide the best level of clinical care
- ❑ Most things referred to as “alternative” treatments are actually the ones with the strongest empirical support for pain management (e.g., CBT, interdisciplinary rehabilitation, relaxation techniques)

# No Alternatives: Approach

- ▣ “Need” for opioids
  - ▣ “If you won’t give me what I need then I guess I will have to go to the street/somewhere else to get them.”
- ▣ Reinforce rationale for decision which is based on maximizing safety for patient and minimizing risk
- ▣ Do all possible to create an environment where patient makes the most adaptive choice – the choices, however, are ultimately personal/individual and left to them

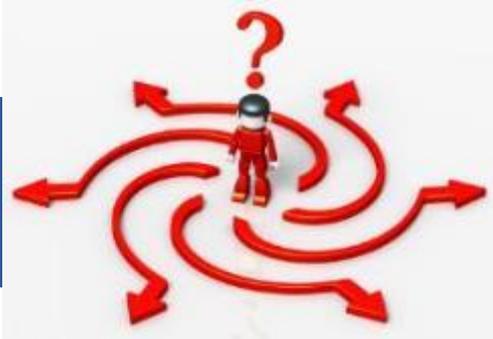


## During Tapering: Other Issues

- ▣ An increase in psychiatric symptoms may occur
  - ▣ Opioids may have masked emotional symptoms as much/more than pain
  - ▣ May have used opioids instead of psychotropic meds or therapy to “manage”/numb symptoms
- ▣ Be prepared to address increases in anxiety and other emotional issues
  - ▣ Person may have used opioids for years so clinical care in explaining symptoms, etc. is key
  - ▣ May necessitate referral for evaluation, EBP, etc.

## During Tapering: Other Issues

- ▣ Significant somatic focus on withdrawal symptoms, any physical stimulus
  - ▣ The population is more focused on physical sensations, may have tendency to catastrophize, revert to the need for medical ‘answers’
- ▣ Variability in response
  - ▣ Some may experience less withdrawal effects, others more
    - ▣ Sometimes related to type of opioid (e.g., methadone half life, Fentanyl patch)

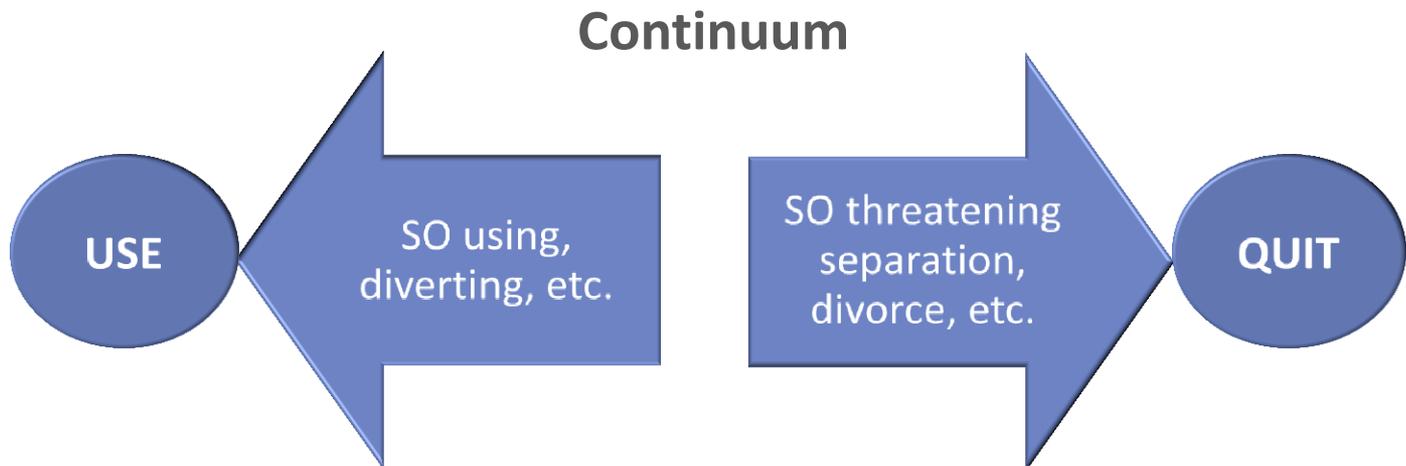


## During Tapering: Other Issues

- ▣ Desire to abandon taper *“I can’t...”*
  - ▣ For some beginning is the most difficult as they have not decreased (perhaps in years)
  - ▣ For others, they may start out well but then regress, particularly when faced with challenge
- ▣ Provide support and remind of reasons, personal and medical, that this is occurring
- ▣ Share success stories of others; have peers share directly if possible/positive testimonials

# Social Setting and Significant Others

- ▣ Education to social network is key
  - ▣ Spouses, parents, etc. typically need the same education regarding chronic pain and most effective long-term treatment options as patients





## Setting and Significant Others

- ▣ Solicitous other may contribute unwittingly to ceasing of taper and/or embracing of sick role
  - ▣ “Mistake of love”
  - ▣ Similar fears
  - ▣ Foster dependence
  
- ▣ On the other hand, can be a primary motivator to taper
  - ▣ “My husband says he misses me... I’m afraid he may leave me”
  - ▣ Value of stable family when making significant change
  - ▣ “Have you heard any positive feedback from your family since you started tapering?”

# Provider Considerations

# Triage Options

- ▣ Know your limits and refer as indicated – it takes a team:
  - ▣ Substance use counseling
  - ▣ Suboxone
  - ▣ Pain rehabilitation program
  - ▣ Psychological interventions
    - ▣ CBT-CP, ACT, etc.
  - ▣ PMRS therapies
    - ▣ PT, OT, pool



# Plan for Success

- ▣ Concrete plans
  - ▣ Review/generate specific plans for difficult times to reduce fear and respond to challenges – expect for this to be hard at times and plan for it
- ▣ Distraction is key
  - ▣ Relaxation, pleasant activities, socialization
  - ▣ Focus the conversation on positives, adaptive options – frequent redirection is needed

# Opioid-Related Provider Issues

- ▣ Often feel pulled, pressure
- ▣ As a provider, be aware of own reactions and how those may contribute to interaction
- ▣ **Be FACT-based not emotion-based**
  - ▣ DO NOT let emotions prevail over facts and reason
  - ▣ Emotional pleas pull for emotional reactions – the right thing is often the difficult thing for providers

# Opioid-Related Provider Issues

- ▣ *Opioid Cessation: When, Why and Especially How* (2013)  
American Pain Society Annual Conference symposium by  
A. Mariano, J. Murphy, M. Hooten, M. Clark<sup>11</sup>
  - ▣ Themes
    - ▣ Ethical/Professional Obligations
    - ▣ Guilt
    - ▣ Blame
    - ▣ Fear
    - ▣ Challenge Competence

# Themes

- ❑ There's no reason anyone should suffer the way I am suffering.
- ❑ Maybe if you had the kind of pain I have you would understand and not be so heartless.
- ❑ I was doing just fine on these medications, now I can't do anything.
- ❑ I don't think I can go on living without these medications.

# Themes

- ▣ I'm going to file a complaint with the Director/Congress...
- ▣ If these medications are so bad then why did you all give them to me in the first place?



## Key Messages

- ▣ Reassure patient that *you are not abandoning them*
  - ▣ Share that the right/best things are often tough...  
assure they will get through and support is there
- ▣ Goal is to assure safety while supporting and educating
- ▣ This is the therapeutic thing – the role of opioids are at best limited in the chronic pain management plan: medication is one piece of a very big puzzle



## Key Messages

- ▣ As a provider, stay the course
  - ▣ Focus on minimizing mental and physical distress
    - ▣ Addressing fears
    - ▣ Ensuring safety
  - ▣ Be empathic but not apologetic
  - ▣ The right thing is often not the easy thing – this is an appropriate medical decision and the therapeutic choice
  
- ▣ This is what helping looks like!

# Putting It All Together

- ❑ Evaluate carefully and individualize care to increase motivation, commitment, and compliance
- ❑ Be direct and open regarding expectations
- ❑ Remain confident – appreciate the patient’s perspective but be committed to doing the right thing

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# Resources

- For more information about the 3-week, inpatient Chronic Pain Rehabilitation Program at the Tampa VA including referral information please visit our website at:  
[http://www.tampa.va.gov/services/Chronic Pain Rehabilitation Program.asp](http://www.tampa.va.gov/services/Chronic_Pain_Rehabilitation_Program.asp)
- For more the Cognitive Behavioral Therapy for Chronic Pain Therapist Manual, please visit the Opioid Safety Initiative Toolkit information on the national VA management website at:  
[http://www.va.gov/PAINMANAGEMENT/Opioid Safety Initiative Toolkit.asp](http://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_Toolkit.asp)

**Thank You! Questions?**



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