PAINWEEK®

# Misunderstood Villains: Communication Strategies to Bridge the Divide

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# Biography

David Cosio, PhD, ABPP is the psychologist in the Pain Clinic and the CARF-accredited, interdisciplinary pain program at the Jesse Brown VA Medical Center, in Chicago. He received his PhD from Ohio University with a specialization in Health Psychology in 2008. He completed a behavioral medicine internship at the University of Massachusetts-Amherst Mental Health Services and a Primary Care/Specialty Clinic Post-doctoral Fellowship at the Edward Hines Jr. VA Hospital in 2009. Dr. Cosio has done several presentations in health psychology at the regional and national level. He also has published several articles on health psychology, specifically in the area of patient pain education. He achieved specialist certification in Clinical Health Psychology by the American Board of Professional Psychology in 2017.

There is no conflict of interest and nothing to disclose.

# Disclosure

Dr. Cosio is speaking today based on his experiences as a psychologist employed by the Veterans Administration. He is not speaking as a representatives of or as an agent of the VA, and the views expressed are his own.

# Learning Objectives

- Describe the challenges faced in this therapeutic relationship in the pain management setting, specifically around opioid tapering
- Discuss how effective communication leads to rewarding relationships and its effect on pain outcomes
- Identify ways to improve communication in the opioid tapering process
- Discuss motivational interviewing principles

# Being the Villain

What do Darth Vader, Batman's Joker, and Hannibal Lecter all have in common?

# Being the Villain

- All famous pop culture villains
- They are venerable opponents to their respective protagonist
- They often have many of same characteristics as “hero,” but are misguided in pursuits
- In many cases, pain patients and providers are made out to come across in same way

## Why is this?

# Difference in Perspectives

## Patient Perspective

- Patients living with chronic pain may present with several challenges:
  - –social or financial problems
  - –a lack of trust or communication
  - –cultural differences or language barriers
  - –cognitive impairment
  - –severe mental health issues
  - –addiction concerns
  - –healthcare system concerns
  - –personality conflicts

## Healthcare Provider Perspective

- Healthcare providers may make common mistakes:
  - –use jargon or avoid certain topics
  - –assume understanding on behalf of patient
  - –not realize patient may be afraid to assert themselves
  - –make inappropriate jokes
  - –fail to explain their hospital and/or clinic's function
  - –made to feel like a police officer, judge, or dealmaker

# Relationship Expectations

Patient is expected by provider to:

- be open
- honest
- obedient
- motivated to get better
- display gratitude
- display pleasure at improvement

Provider is expected by patient to:

- be thoughtful
- listen
- be empathic
- be non-judgmental
- do no harm
- be competent

# Bridge the Divide

Bridging the divide between both individuals is needed for optimal pain management, which ultimately rests on their combined relationship

# The Therapeutic Relationship

- Therapeutic relationship (also therapeutic alliance, helping alliance, or working alliance) refers to relationship between a healthcare professional and a patient
- Research on statistical power of therapeutic relationship now reflects more than 1,000 findings
- It has been found to predict treatment adherence, agreement, and outcome across a range of patient diagnoses and treatment settings

Grencavage LM, Norcross JC. Where are the commonalities among the therapeutic common factors?. Prof Psychol Res Pract. 1990;21(5):372-378.

# The Therapeutic Relationship

- In humanistic approach in psychology, Carl Rogers identified a number necessary and sufficient conditions that are required for therapeutic change to take place
- These include: authentic/genuineness, unconditional positive regard, and empathy
- Patient-provider relationship is key mediator between perceived helpfulness & patient satisfaction and has been found to be significantly associated with chronic pain outcomes

Farin E, Gramm L, Schmidt E. The patient–physician relationship in patients with chronic low back pain as a predictor of outcomes after rehabilitation. J Behav Med. 2013;36(3):246-258.

Ferreira PH, Ferreira ML, Maher CG, et al. The therapeutic alliance between clinicians and patients predicts outcome in chronic low back pain. Phys Ther. 2013;93(4):470-478.

Vowles KE, Thompson M. The patient-provider relationship in chronic pain. Curr Pain Headache Rep. 2012;16(2):133-138.

# Relationship Challenges

- Chronic pain patients and providers have opposing attitudes and goals
  - One tries to control other
  - Someone asserts control and other concedes
  - Leads to tension and discomfort in treatment

- Problems increase with time:
  - power struggles
  - increased feelings of stigmatization
  - distrust

Hinchey SA, Jackson JL. A cohort study assessing difficult patient encounters in a walk-in primary care clinic, predictors and outcomes. J Gen Intern Med. 2011;26(6):588-594.

# Relationship Challenges

- Patient wants legitimization of pain and feel questioned and try to be more credible
- Provider wants to avoid feeling powerless—no cure, no improvement, no consolation

# Relationship Challenges

- Patients perceive providers as:
  - lacking in empathy
  - doubting their pain is real
  - influenced by stereotypes
- Perception of clinicians:
  - more concerned about other urgent health conditions
  - looking for objectivity within a subjective condition
  - not taking ample time to build relationship of trust

Frantsve LM, Kerns RD. Patient–provider interactions in the management of chronic pain: current findings within the context of shared medical decision making. Pain Med. 2007;8(1):25-35.

Bergman AA, Matthias MS, Coffing JM, Krebs EE. Contrasting tensions between patients and PCPs in chronic pain management: a qualitative study. Pain Med. 2013;14(11):1689-1697.

# Communication Strategies to Bridge the Gap

- One area of research demonstrating the central role of patient-provider communication is in opioid tapering process
- Communicative challenges are often especially exacerbated when patients are being tapered down or off opioids
- Matthias and colleagues conducted a study to understand communication processes specifically related to opioid tapering in order to identify best practices and search for opportunities for improvement
- Four themes, under the acronym M.E.A.N., emerged from their investigation

Matthias MS, Johnson NL, Shields CG, et al. “I’m not gonna pull the rug out from under you”: patient-provider communication about opioid tapering. J Pain. 2017;18(11):1365-1373.

# Being M.E.A.N.

- Managing difficult conversations
  - When patients and providers did not reach a shared understanding, difficulties and misunderstandings arose
- Explaining
  - Patients needed to understand individualized reasons for tapering, beyond general, population-level concerns such as the potential for addiction
- Assuring non-abandonment
  - Patients needed to know that their providers would not abandon them throughout the tapering process
- Negotiating
  - Patients needed to have input, even if it was simply the rate of tapering

# “It’s NOT Easy Being Mean…”—Evil Kermit

- It is understood that pain and opioid management are communicative activities, and that it is sometimes challenging
- These findings underline importance for both patients and providers to make improvements in communication
- Increased attention to communication has been proposed as a way to improve relationship

# Communication Pathways

- Seven pathways to better health through communication

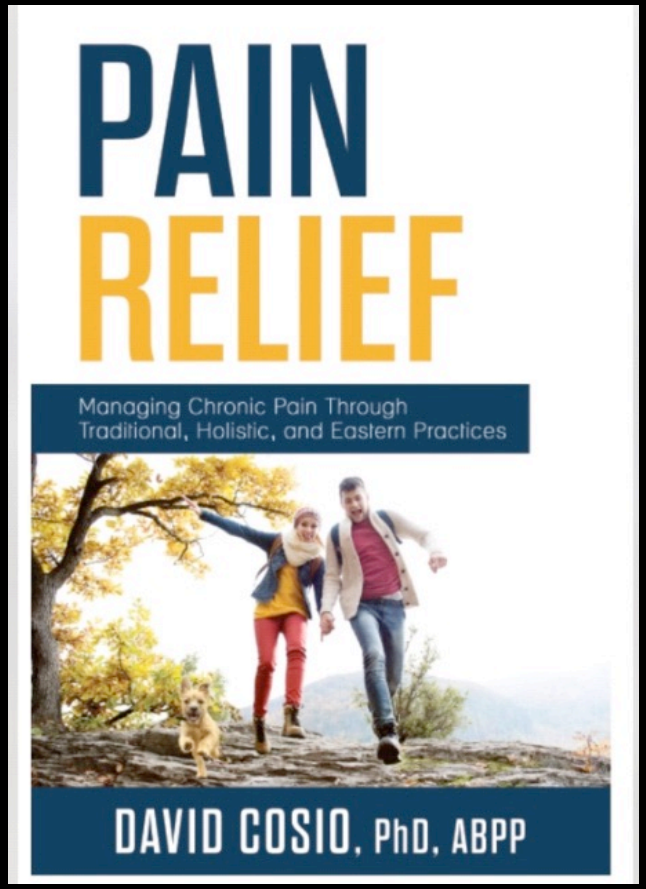
1. Increased access to care
2. Greater patient knowledge and shared understanding
3. Higher quality medical decisions
4. **Enhanced therapeutic alliances**
5. Increased social support
6. Patient agency and empowerment
7. Better management of emotions

# Improving Communication

- Invest in beginning
  - Create rapport
  - Let patient tell their “STORY”
- Elicit patient’s perspective
  - Ask patient for ideas, requests, and how impact their life
- Demonstrate empathy
  - Be aware of your own reactions and be open to patient emotions
- Invest in end
  - SMD, patient education, and provide diagnosis

# Communication Skills

- Effective communication is one of most important life skills
- We don't usually put a lot of effort into this skill set
- There are 5 essential components to effective communication
  - Really listen
  - Express empathy
  - Be concise
  - Ask questions and reflect
  - Watch your body language



# Listening is NOT…

1. Ordering, directing, or commanding
2. Warning or threatening
3. Giving advice, making suggestions, or providing solutions
4. Persuading with logic, arguing, or lecturing
5. Moralizing, preaching, or telling patients their duty
6. Judging, criticizing, disagreeing, or blaming
7. Agreeing, approving, or praising
8. Shaming, ridiculing, or name calling
9. Interpreting or analyzing
10. Reassuring, sympathizing, or consoling
11. Questioning or probing
12. Withdrawing, distracting, humoring, or changing the subject

# Listening IS…

- Making a conscious effort to hear what the patient is saying and what message is being communicated
- Giving patient undivided attention and acknowledging them as an individual

# Express Empathy

- Empathy is ability to understand and share feelings of another
- See the world through their eyes
  - you cognitively understand what they are saying and can see it from their point of view
- No judgement
  - we need to see person as a human being – someone who is valuable in their own right
- Understand feelings
  - we need to get in touch with our emotions in order to truly connect with another person's feelings
  - *A common reason to skip this element of empathy: we don't have our own emotions sorted out*
- Communicate understanding
  - make someone feel like they are being understood – that they are seen and heard
  - *If you don't know what to say, say, "It sounds like you're in a hard place now. Tell me more about it."*

# Be Concise

- Offer information, but don’t impose it
- Ask permission—do patients want information?
- Provide the information in context of other patients
- Give patients implicit or explicit permission to disagree with you
- Use a menu of options
- Use patient’s statements
- Give information that is factually or normatively based
- Invite patients to decide what the information means for them
- Remember, your patient is a person, not an information receptacle

# Use Summaries

- Summaries are a special type of reflection where provider recaps what has occurred in all or part of an appointment
- Summaries communicate interest, understanding, and call attention to important elements of the discussion
- They may be used to shift attention or direction and prepare patient to “move on”
- They can highlight patient’s readiness to change

# Ask Questions

- Open-ended questions are not easily answered with a "yes/no" or short answer
- Open-ended questions invite elaboration and thinking more deeply about an issue
- Although closed-ended questions have their place (e.g., assessment), open-ended questions create forward momentum

# Reflecting

- Simple
  - –stays very close to what person said
- Paraphrase
  - –goes well beyond what person said and presents information in a new light
- Affective
  - –addresses emotion either expressed or implied
- Amplified
  - –pushes on an absolute statement by person
- Double-sided
  - –acknowledges both sides
- Metaphor
  - –moves well beyond content to provide a model for understanding

# Watch Your Body Language

- Fidgeting
  - conveys being nervous
- Looking up or looking around
  - natural cue someone is lying
- Staring
  - can be interpreted as aggressive
- Failing to smile
  - can make people uncomfortable
- Stepping back when you're asking for a decision
  - conveys fear
- Standing with hands on hips
  - is an aggressive posture
- Checking your phone or watch
  - says you want to be somewhere else

# Watch Your Body Language

- Holding your hands behind your back (or firmly in your pockets)
  - looks rigid and stiff
- Leaning back too much
  - come off lazy or arrogant
- Leaning forward
  - can seem aggressive
- Breaking eye contact too soon
  - seem untrustworthy or nervous
- Nodding too much
  - nod once and then try to remain still
- Pointing with your hands
  - feels aggressive
- Crossing your arms
  - you look defensive
- Steepling your fingers or holding palms up
  - conveys weakness

# Motivational Interviewing

- Another technique that may be used to improve communication for behavioral change
- Developed in early 1980s in treatment of addictive behaviors, such opiate use
- A patient-centered, directive technique, MI aims to improve the motivation and commitment of patients to achieve behavioral changes
- MI principles now applied to management of chronic conditions, such chronic pain
- It promotes patient's physical and psychological functions and maintains their compliance with exercise for coping with pain


Miller WR, Rollnick S. Motivational interviewing: preparing people to change addictive behavior. New York, NY: Guilford Press. 1991.

Jensen MP, Nielson WR, Kerns RD. Toward the development of a motivational model of pain self-management. J Pain. 2003;4(9):477-492.

Ang D, Kesavalu R, Lydon JR, Lane KA, Bigatti S. Exercise-based motivational interviewing for female patients with fibromyalgia: a case series. Clin Rheumatol. 2007;26(11):1843-1849.

Habib S, Morrissey S, Helmes E. Preparing for pain management: a pilot study to enhance engagement. J Pain. 2005;6(1):48-54.

Vong SK, Cheing GL, Chan F, So EM, Chan CC. Motivational enhancement therapy in addition to physical therapy improves motivational factors and treatment outcomes in people with low back pain: a randomized controlled trial. Arch Phys Med Rehabil. 2011;92(2):176-183.

# Motivational Interviewing

- The approach aims to influence people in their initiation, intensity, and performance of a behavior, such as self-management skills for pain reduction
- This technique promotes physical and psychological function, and helps maintain compliance with exercise for coping with pain
- Shown to affect treatment outcomes such as in functional improvement and motivation to receive treatment

Geen RG. Introduction to the study of motivation. In: Human motivation: a social psychological approach. Pacific Grove, CA: Brooks/Cole Publishing. 1995.

Jensen MP, Nielson WR, Kerns RD. Toward the development of a motivational model of pain self-management. J Pain. 2003;4(9):477-492.

Vong SK, Cheing GL, Chan F, So EM, Chan CC. Motivational enhancement therapy in addition to physical therapy improves motivational factors and treatment outcomes in people with low back pain: a randomized controlled trial. Arch Phys Med Rehabil. 2011;92(2):176-183.

# What Makes It Motivational Interviewing?

1. Is a conversation about change
2. Has a particular purpose
3. Is collaborative
4. Honors autonomy and self-determination
5. Is evocative
6. Uses specific skills
7. Is goal-oriented
8. Attends to specific forms of speech
9. Responds to change-talk in specific ways
10. Responds to resistance

# Readiness to Change

- Ambivalence is normal
- Change is nonlinear
- Readiness is not static
- Attend to readiness in work

# Elements of MI

- MI Principles
- MI Strategies
  - OARS
    - Open-ended questions
    - Affirmations
    - Reflective listening
    - Summaries
  - Eliciting Change Talk
- MI Spirit

# MI Principles

- There are four main principles to use when applying MI:

1. Expressing accurate empathy
2. Developing discrepancy
3. Avoiding argumentation and rolling with resistance
4. Supporting self-efficacy


Jensen MP. Enhancing motivation to change in pain treatment. In: Turk DC, Gatchel RJ, eds. Psychological approaches to pain management: a practitioner's handbook. New York, NY: Guilford Press. 2002:71-93.

# OARS: Affirmations

- Affirmations are statements that recognize patient's strengths
- They assist in building rapport and in helping patient see themselves in a different, more positive light
- To be effective they must be congruent and genuine
- The use of affirmations can help patients feel that change is possible even when previous efforts have been unsuccessful
- Affirmations often involve reframing behaviors or concerns as evidence of positive patient qualities
- Affirmations are a key element in supporting self-efficacy

# Sample Affirmations

Commenting positively on an attribute

– *“You are determined to get your health back.”*

A statement of appreciation

– *“One can appreciate your efforts despite the discomfort you’re in.”*

A compliment

– *“Thank you for all your hard work today.”*

Recognizing patient strengths and countering a defeatist attitude

– *“It’s impressive that you’ve been trying to quit despite all the stress you’re going through.”*

# Affirmation Pitfalls

- Focus on specific behaviors instead of attitudes, decisions, and goals
- Avoid using the word “I”
- Focus on descriptions and not evaluations
- Attend to non-problem areas rather then problems
- Think of affirmations as attributing interesting qualities to patients
- Nurture a competent instead of a deficit worldview of patient

# What is Change Talk?

- Change talk is defined as statements by the patient revealing consideration of, motivation for, or commitment to change
- In MI, the provider seeks to guide the patient to expressions of change talk as the pathway to change
- Research shows that the more someone talks about change, the more likely they are to change
- There are different types of change talk

# Recognizing & Reinforcing Change

## Preparatory Language

- Desire to change
  - *"This is not the person I want to be."*
- Ability to change
  - *"I know what I have to do—I just need to do it."*
- Reasons for change
  - *"It would be nice if I didn't have to worry so much."*
- Need to change
  - *"I've got to make things better."*

## Mobilizing Language

- Commitment
  - *"I will make (specific) changes."*
- Activation
  - *"I am prepared and willing to make changes."*
- Taking steps
  - *"I went to the store, bought some vegetables, cleaned and cut them up, and have them in my fridge for snacks."*

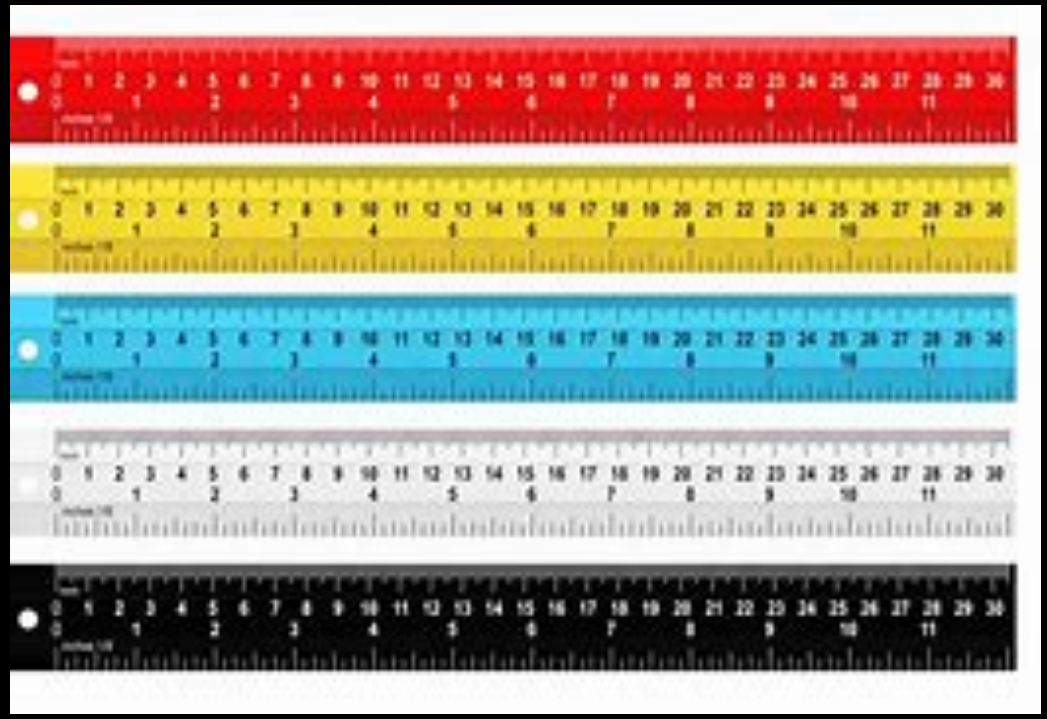
# Eliciting & Strengthening Change

1. Ask evocative questions
   - an open-ended question, answer to which is likely to be change talk
2. Ask for elaboration
   - ask for more details when change talk is present
3. Use extremes
   - what are worst/best things that might happen if they don't make this change?
4. Looking back
   - ask about a time before target behavior emerged and how different
5. Looking forward
   - ask what may happen if things continue as they are
6. Exploring goals
   - ask patient what they want in life. Ask how continuation of target behavior fits in with patient's goals

# Assessment/Feedback of Change

Readiness Rulers:

- "On a scale from 1 to 10, how important is it to you to change (specific behavior), where 1 is not important and 10 is very important?"
- "And why are you at ___ and not ___ (a lower #)?"
- "How confident are you that you could make the change if you decided to do it?"
- "And why are you at ___ and not ___ (a lower #)?"

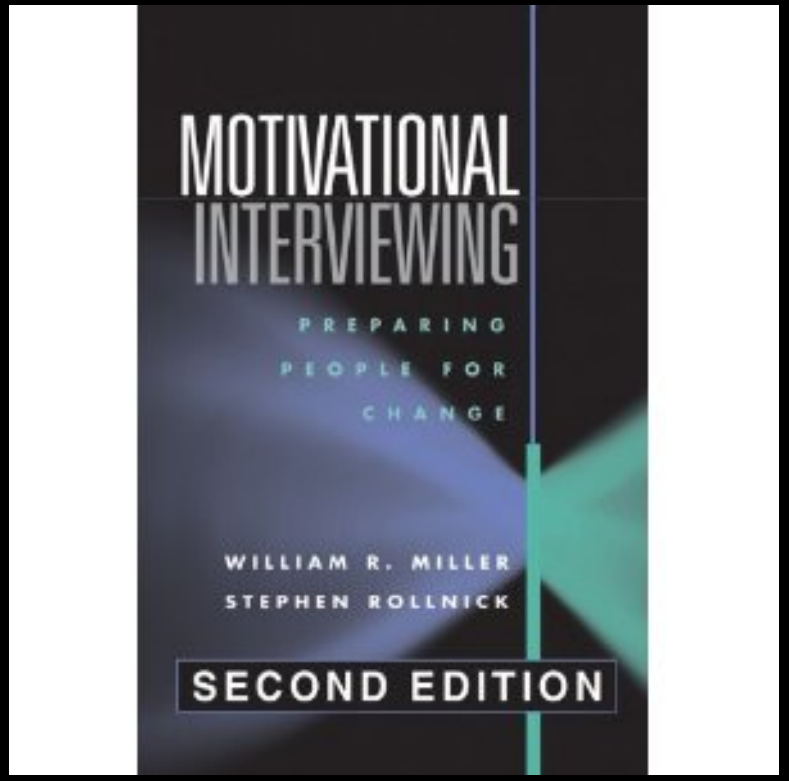


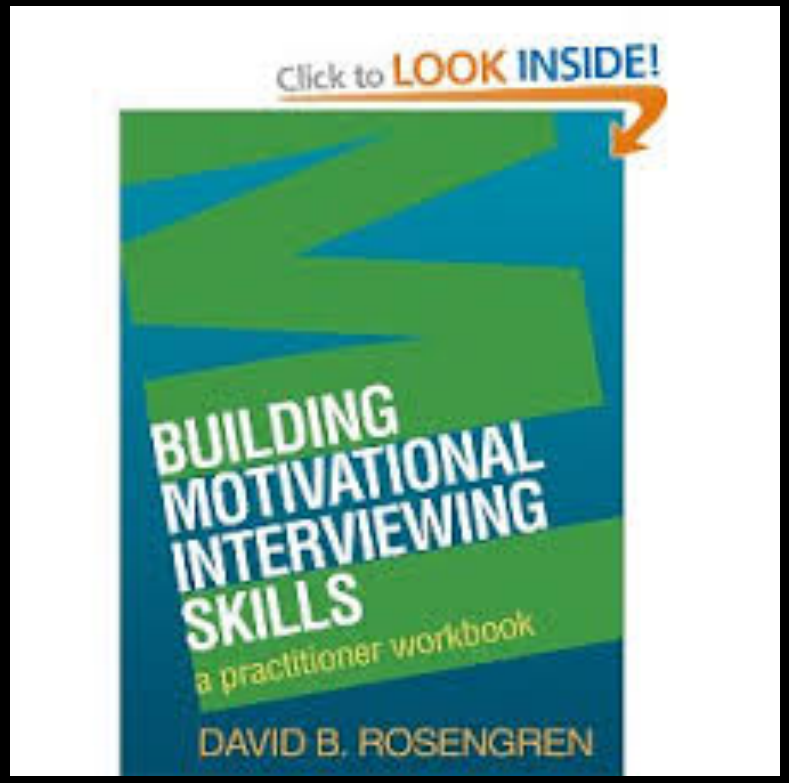
# The Key Question

## What is next?

- “Given what you told me, what do you think you will do next?”
- “Where do you think you would like to go from here?”
- “What’s your next step?”

# MI Resources



# What Type of Villain Are You?