Tapering opioids using motivational interviewing

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Please imagine the following situation. You are a physician with a busy family medicine practice. Today one of your patients who lives with chronic pain and takes a high dose of a prescription opioid has an appointment with you. From the patient's report of pain and function, it seems she is getting minimal benefit from the opioid.[1] Limited evidence available suggests that an opioid taper might actually result in improvement in overall pain and function.[2] You would like to propose a taper of the opioid dose, and perhaps even stop it, but in the past when you have introduced this topic to your patient you have encountered resistance. The patient's resistance has been expressed in various ways: "It is just not a good time for that." "Who knows if that would even help?" "If you take this away, what will I be left with?" "It is the only thing that helps me to get through the day!"

What should you do? Is there a way to guide your patient into accepting the idea that tapering her opioid could bring benefits? How can you help your patient *choose* to try an opioid taper?

One approach is called *motivational interviewing*. This approach encourages a patient to articulate his or her own reasons to change and explore the discrepancy between the arguments for and against change.[3] It applies 3 communication skills—listening, asking, and informing—to help patients who are ambivalent or resistant to change. The spirit of motivational interviewing has been described as collaborative, evocative, and honouring of patient autonomy.[3] RxFiles has developed a chart on the skills of motivational interviewing, which is available at **CFPlus**.*

Many health care providers are already adept at listening, asking, and informing. A motivational approach is simply a refined application of these skills, with the specific goal of enabling behavioural change. Using this approach might feel both familiar and challenging, particularly for difficult interactions—that is, the ones that become confrontational or feel like an argument. In these cases, a motivational approach provides new communication tools. In the long run, health care providers who use a motivational approach report more rewarding and effective interactions with their patients.

In this article we will exemplify the use of motivational interviewing in a case specific to opioids by presenting an annotated version of how a conversation might go between a male physician attempting to use a motivational approach with a patient who takes opioids. For a quick reference on motivational interviewing specific to opioids, you can find a motivational interviewing pocket card at **CFPlus**.* **Box 1** shows several other RxFiles resources that are available on opioids.

*The **RxFiles chart** and **pocket card on motivational interviewing** are available at **www.cfp.ca.** Go to the full text of the article online and click on the **CFPlus** tab.

Box 1. Additional resources on opioids by RxFiles

The following RxFiles resources can be found at **www.RxFiles.ca**

- A **patient booklet** that answers questions about opioids, which can help patients reconsider their use of opioids
- A **pain colour chart** that describes some of the alternatives to opioids for pain management
- A **newsletter on opioid tapering** that describes some useful strategies to create a successful tapering plan

Part 1: Creating change talk by listening

Doctor: Hi, Mrs Johnson. It's very good to see you again. When I saw you a few months ago we talked a little about your chronic low back pain. I'm wondering, how are things going with that?

Mrs Johnson: Um, not that well actually. I was hoping to talk to you about that today.

Doctor: Can you remind me what you're taking for pain?

Mrs Johnson: Right now I take my long-acting morphine twice a day. And I take my short-acting morphine 4 times a day—usually around each meal and before I go to bed. And I take acetaminophen at the same time as my morphine.

Doctor: And it's not going as well as you'd like.

Mrs Johnson: That's an understatement. Doctor, the pain is so terrible. I wake up, and I feel like crap. Most days I can hardly get out of bed. It doesn't really get better throughout the day. So I can't do any of the things I want.

Doctor: Your pain is holding you back from doing things you enjoy.

Mrs Johnson: Very much! I want to play with my kids, and get back to cooking and laundry, but it's impossible for me with this pain.

Doctor: You want to get back to a normal life, but the morphine isn't helping you do that right now.

Mrs Johnson: Exactly. I need something more, which is why I came to ask you if we could go up on the dose again.

Doctor: You're wondering if a higher dose might work better.

Mrs Johnson: I know it will. In the past when we increased the dose I always felt better.

Doctor: And maybe you were able to play with your kids and cook again.

Mrs Johnson: Well, no, but I did feel like I could forget about the pain. And it's not like I'm on a high dose or anything.

Doctor: You can't see any problems with your dose of morphine.

Mrs Johnson: I mean, I wouldn't quite say that. I do feel just a little out of it sometimes. Like my kids have to repeat things to me sometimes.

Doctor: And that bugs you a bit.

Mrs Johnson: Yeah, I think to myself, *I'm only 43! And I feel like I'm 90!*

Doctor: It doesn't feel good to feel that way. You're wondering if it's the morphine that's making you feel that way.

Mrs Johnson: Oh, it's definitely the morphine. But what am I supposed to do? I can't go without it.

A clinician's goal in motivational interviewing is to guide the patient toward change. *Change talk* describes patient statements that indicate a desire, ability, reason, or need for change (**Table 1**).[3] One of the best ways to create an environment amenable to change talk is to fully hear and understand the patient through active listening.

Our physician in the above scenario is using reflective listening statements. He is not trying to agree or disagree, to sympathize or to persuade.[3] Instead, he is attempting to reflect back what the patient is saying to him in that moment. He has formed a hypothesis of what he thinks the patient means, and then is attempting to repeat it with somewhat different words. It is almost as if he were trying to "continue the paragraph"—anticipating what the patient might say next but what is still unsaid.[3]

Throughout all this, our physician is keeping an ear open for change talk. Several times in the conversation, Mrs Johnson describes why she might be motivated to change: She wants to play more with her kids and do household chores. She wants to get rid of the pain. She does not like feeling older than her age. Each time he hears change talk, our physician makes sure to reflect it back. Thus the patient hears her own arguments for change.[3]

Our physician is also *rolling with resistance*; that is, he is not jumping in and correcting the patient's perspective.[3] Let's examine his response to the patient's statement that she is not on a high dose of morphine. Rather than agreeing or disagreeing with this statement, he instead reflects back what he thinks the patient is trying to say. Of note, these reflections are not questions, and they are not delivered sarcastically. Rather, they are statements, and our physician's voice is inflecting down at the end of each reflection.[3]

Rolling with resistance is challenging! It is much easier to just "set the patient straight." For example, our physician might have been tempted to say, "Actually, your dose of morphine is quite high." Unfortunately, sometimes when we take this approach patients will "dig in" and begin to argue against change. Instead, in the scenario above, rolling with resistance caused the patient to engage in more change talk. The patient heard her words repeated back, and realized they were not quite right—that she was actually having a few problems with morphine.

Table 1. Recognizing change talk in patients

KINDS OF CHANGE TALK	STATEMENTS THAT INDICATE THE KIND OF CHANGE TALK
Desire	"I want to ..."
	"I would like to ..."
	"I wish ..."
Ability	"I could ..."
	"I can ..."
	"I might be able to ..."
Reasons	"It would be better if ..."
Need	"I need to ..."
	"I have to ..."
	"I really should ..."

Data from Rollnick et al.[3]

Part 2: Creating change talk by asking

Doctor: You mentioned just now that you've been feeling older than your age. Let's say we left your morphine dose the same and continued it for the next 5 years or so. What do you think life would be like in 5 years?

Mrs Johnson: Hmm. You know, I've never really thought about things that way ... usually I'm just focused on today ....

Doctor: The pain makes it tough for you to think about the future.

Mrs Johnson: Right. Exactly .... Well, I definitely want to be off of morphine in 5 years. I want my pain to be gone long before then. And I don't want to have side effects for that long.

Doctor: You don't really see yourself on the morphine long term. Too many side effects for that.

Mrs Johnson: If the pain got better, I would want to stop the morphine.

Doctor: You would stop it, if you could.

In part 1, we talked about one of the key skills of motivational interviewing: listening. The second key skill we will discuss is asking.

The purpose of asking is to create an opportunity for the patient to weigh his or her choices, and explore what change might look like. This is done with a spirit of genuine curiosity, avoiding disapproval to prevent a patient from becoming defensive. Asking the right questions also helps. In general, the questions used in motivational interviewing should try to create change talk. **Box 2** lists some examples of questions to promote change talk in opioid use.

Box 2. Useful questions to promote opioid change talk

The following are examples of questions to help initiate change talk about opioid use:

- From your perspective, what are the upsides and downsides to continuing to taking opioids?
- How is your life now, compared with before you started taking opioids?
- Suppose you continued taking opioids for the next 5 years. What would that be like?
- Are there any benefits to not taking opioids anymore?

Motivational interviewing works best when the key skills are used together—for example, combining asking with listening. Following a question with reflections helps prevent patients from feeling like they are being peppered with questions, and helps to completely unlock all the potential change talk that can be generated by each question. One rule of thumb is to use at least 2 or 3 reflections for every question you ask.

Please examine the question our physician asked the patient above: "What do you think life would be like in 5 years?" This question is designed to bring out a patient's desires, and in this case it does: She wants to be off morphine by then. The physician, hearing that word *want,* recognizes change talk (**Table 1**)[3] and is careful to use reflective listening to repeat the change talk back to her. Thus the patient gets to hear yet another one of her own arguments for change, and the likelihood of change continues to rise.

Part 3: Creating change talk by informing

Doctor: May I share some information with you?
Mrs Johnson: Yes.
Doctor: This might surprise you. It surprised me as well when I learned it. But for some people out there, when we go higher on their opioid dose, their pain actually gets worse. And so this might seem hard to believe, but for these folks when we give them less morphine they actually have less pain. This is called *opioid-induced hyperalgesia*.
Mrs Johnson: Well, that seems so backward.
Doctor: That doesn't quite ring true to you.
Mrs Johnson: I know it's not true for me. How can it be? When I'm late in taking my morphine, I notice it. The pain comes back right away. So the morphine is definitely doing something.
Doctor: You feel the morphine is helping, because you have pain when you don't take it.
Mrs Johnson: Exactly.
Doctor: May I make an observation?
Mrs. Johnson: Of course.
Doctor: What you just said doesn't really surprise me. We know that with opioids, the body gets used to having them there. And so when they're gone, even for a short period of time, the body feels withdrawal. Withdrawal is painful! And withdrawal pain can feel exactly like your usual low back pain. What I'm trying to say is that maybe your body is being tricked into thinking the morphine is working, even though it's really just keeping withdrawal at bay.
Mrs Johnson: Hmm.
Doctor: What do you think about that?

The final key skill of motivational interviewing is informing. Informing is typically done only after asking permission, and not in the form of a lecture. Rather, the goal is to provide information in the role of a guide.[3]

One approach is to use a technique called *elicit-provide-elicit*.[3] First, elicit permission to provide information. This can be done directly as the doctor did in the scenario above, or it can be done indirectly with an open-ended question such as, "What would you like to know about this?" Second, provide information in a manageable amount. Third, elicit again as a follow-up to determine the patient's response to the information just provided.

In the scenario above, notice how our physician used 2 cycles of the elicit-provide-elicit technique. He asked permission before providing advice each time, and followed his advice with a check to see what the patient thought about it. In between, he mixed in reflective listening in order to defuse any defensiveness. The result was a patient who was willing to at least consider what our physician had to say.

Patients often have strong opinions about opioids, and it can be difficult to provide information on this topic without encountering defensiveness. The RxFiles patient booklet on opioids might help patients understand opioids better and help them reduce their opioid dose (**Box 1**).

Part 4: Reassuring and summarizing

Mrs Johnson: Well, if the morphine isn't helping me, then why did you start it in the first place?
Doctor: You almost wish we hadn't started it at all.
Mrs Johnson: Well, no, I remember being happy that we started it at the time. I was in so much pain.
Doctor: And what you're worried about right now is that without the morphine, your pain will be even worse.
Mrs Johnson: Yes, exactly.
Doctor: We will work together on this. I'm going to stick with you, and I'm not going to suddenly stop your morphine. I'm hopeful that in the long run without morphine, you will be able to enjoy life more, and maybe even have less pain overall. And I've got some ideas for some things we could try that aren't morphine.
Mrs Johnson: Well, it makes me feel better to know you aren't going to suddenly stop the morphine.
Doctor: Good! Let's summarize, because we've covered a lot so far. Your pain is very bad, and prevents you from doing the important things, like playing with your kids and doing chores around the house, even though you are on the morphine. In fact, some days you still can hardly get out of bed. You've been using morphine, and we have increased your dose over time, but it still has not helped you to do the

things you want to do. It also seems like the morphine is making you feel a bit doped up, and in the long run, you don't really see yourself on it. Both you and I want to get your pain under control. You're nervous about decreasing the morphine dose, but you might be willing to give that a shot, as it might actually be making your pain worse. Is that a fair summary?

Mrs Johnson: Yeah, what you just said was right. Doctor, I really do want to get this pain under control.

There was a point in the interview that Mrs Johnson appeared to get upset: "Well, if the morphine isn't helping me, then why did you start it in the first place?" This is not an uncommon patient reaction. However, take a close look at our physician's response. He might have been tempted to defend the decision to prescribe opioids. Instead, however, he chose to use reflective listening, which unearthed the real reason behind Mrs Johnson's resistance: a fear of pain.

Fear of pain explains many of the extreme reactions patients have toward tapering their opioids.[4] Reassurance can go a long way in these patients. In the scenario above, our physician uses reassurance to bring him back to the same side as Mrs Johnson, emphasizing their similar goals: improved function and less pain. Addressing her fear helps her consider tapering morphine as an option, and reminds her that her physician is there to help.

Near the end of this part of the discussion, our physician reflects back all the change talk collected in parts 1, 2, and 3 to the patient as a summary. One way to think about change talk is as *flowers in a field of conversation*.[3] The physician's job in motivational interviewing is to watch for those *flowers to pop up*. Then, every so often, he *offers the flowers back to the patient in a bouquet of change talk*. In this way, the patient hears her own accumulated arguments for change collected together, perhaps for the first time.[3]

Our physician has done a good job of collecting all the reasons why Mrs Johnson might want to change: her pain is bad; her goals are not being achieved; she is experiencing side effects from the morphine; and she does not want to be taking morphine for the rest of her life. He also provides additional reassurance that the overall goal remains to get her pain under control. When he presents all of these reasons to Mrs Johnson at once, he does not find any resistance. This is because she is hearing her own motivations for change.

Part 5: Putting it all together

Doctor: I want your pain to get better too. I have a few suggestions we might consider ....

So far, our physician has made good progress, and there are many ways the rest of this visit might play out. Here is a potential strategy to cap off this interview[5-7]:

- First, use elicit-provide-elicit to *inform* the patient about some nonopioid options that are available. It can be useful to present several options simultaneously. This helps prevent the patient from shooting them all down individually. Some patients might need help adjusting their expectations, as a goal of "zero pain" is usually unrealistic.
- Use *reflective listening* and *asking* to explore which nonopioid options the patient feels confident could work. Watch for, and reflect back, change talk.
- Use elicit-provide-elicit to *inform* the patient about tapering strategies, including the support you could provide. Consider providing stories about what other patients have found to be successful when they tried to taper their opioids.
- *Collaboratively*, decide upon a plan.
- *Ask* how the plan could be incorporated into the patient's daily life. *Reflect* back any change talk.
- *Roll with resistance* if the patient gets nervous about the plan.
- Finish by presenting a *final summary,* reflecting back all the change talk that arose throughout the entire interview.

Conclusion

Tapering opioids is challenging and often necessitates the science, art, and interpersonal skills of medicine to all work together. Even then there is no guarantee of success. Not all patient interactions will go as smoothly as the one detailed in this article. Sometimes your attempts to motivate will struggle to overcome patient resistance and all you will be able to do is plant a seed. In other cases the approach will need to be conducted in small sessions over several months. Nevertheless, in our experience the effort is worthwhile, and motivational interviewing represents a powerful tool for helping patients taper their opioids.

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Competing interests

RxFiles and contributing authors do not have any commercial competing interests. RxFiles Academic Detailing Program is funded through a grant from Saskatchewan Health to Saskatoon Health Region; additional "not for profit; not for loss" revenue is obtained from sales of books and online subscriptions. No financial assistance was obtained for this publication.

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La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro **d'août 2018** à la **page e341.**