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INTRODUCTION

To address the opioid crisis in the United States, leaders in pain care and public health have joined in a widespread effort to curtail the less-than-judicious prescribing of opioid analgesics. Updated clinical practice guidelines increased regulation of prescriptions, and educational outreach helped to decrease serious adverse events related to prescription opioids, including overdose deaths. This effort is an undeniable positive (Johnson et al., 2018). Unfortunately, opioid-related concerns have also been the impetus for a focus on drug management instead of pain management, and people with pain have often suffered because their doctors focused solely on reducing or eliminating opioids. Emphasizing safety in prescribing is critical; however, offering individualized and compassionate care for those who are suffering is also built into the duty to do no harm.

Although most patients using opioids for chronic pain have not misused them, many have developed an overreliance on these medications because opioid properties lead to physical dependence and tolerance. In recent years, too often patients have had their medications changed with limited explanation regarding dose adjustments and have had few options to manage

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suffering. The authors of the Centers for Disease Control and Prevention guideline for prescribing opioids for chronic pain (Dowell et al., 2016) have acknowledged that the guidelines have been misapplied and used in ways beyond their original intent (Dowell et al., 2019). Thus, those with pain are caught in the middle of a societal and political maelstrom in which the headlining opioid epidemic has blurred the line between those who have been prescribed opioids for pain management and those who use opioids illegally (e.g., using heroin or fentanyl; National Academies of Sciences, Engineering, & Medicine, 2017). Signs from suffering protestors read, "Don't punish pain." Unexpected changes in opioid medication may indeed feel like punishment to individuals who have received minimal education about the limitations of pharmaceuticals in chronic pain management and do not fully understand what is needed to achieve optimal functioning as well as analgesia.

The experiences of patients and providers at the intersection of chronic pain and opioids demand more strategies and research for improved management of both concerns. An upside to the stream of negative opioid-related events is increased interest in nonpharmacological approaches to chronic pain management. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* (Institute of Medicine, 2011) called for a "cultural transformation" (p. 2) for pain care in the United States. This report led to major developments in 2016, when both the *National Pain Strategy* (U.S. Office of the Assistant Secretary for Health, 2016) and the *CDC Guideline for Prescribing Opioids for Chronic Pain* (Dowell et al., 2016) were released. Taken together, these publications provide a firm statement that chronic pain is a biopsychosocial condition and must be "treated with integrated, multimodal, interdisciplinary, evidence-based approaches" (U.S. Office of the Assistant Secretary for Health, 2016, p. 3), and that "nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred. . . . If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate" (Dowell et al., 2016). Additional guidelines indicate that optimal treatment should incorporate a variety of options from movement to mindfulness to address pain adequately (Dowell et al., 2016; U.S. Department of Veterans Affairs and Department of Defense, 2017).

Behavioral treatments for chronic pain are not new, and some, such as cognitive behavioral therapy, are backed by decades of research supporting their effectiveness (Eccleston et al., 2013; Ehde et al., 2014; Morley et al., 1999; Skelly et al., 2018). Despite this, the term "pain management" is often

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synonymous with pharmacology and biomedical approaches only, driven in part by the never-ending quest for a simple medical fix. This tendency ignores the reality that chronic pain is a complex condition requiring a comprehensive approach and has no magic bullet. One of the primary problems is that pain is generally understood in terms of an acute or short-term issue; however, chronic pain is a very different phenomenon. Chronic pain cannot be solved with an opioid or any single treatment modality. It is an ongoing condition that must be managed over time, much like Type 2 diabetes—both medical intervention and various behavioral choices affect the trajectory of the disease and its resulting impacts.

Chronic pain conditions are multifactorial and complex on their own; once opioid use is part of the clinical picture, the layers of biopsychosocial considerations grow exponentially. The resulting situation can be challenging for providers to address adequately, as such individuals typically require a higher level of care and treatments that address multiple concerns. Unfortunately, little empirical data are currently available on integrated interventions for pain and opioid use issues. While there is sufficient evidence to create a clear map for addressing the psychosocial factors of pain, there is a gap in the literature on best practices and a shortage of clinical resources for those with a more complex constellation of symptoms. Better pain treatments are important for curtailing the opioid concerns, but if we try to address only pain without considering the role of opioids in patients' experiences, we are not being honest or complete in our approach.

Typically, treatment settings are aimed at either pain or opioids, but not both, and it is not uncommon to be denied pain treatment options in the presence of opioid concerns. Too often, fingers are pointed from one treatment area to another—providers whose focus is addressing opioid misuse convey the message "If you could get the patient's pain under control, then we wouldn't have these problems!" Similarly, pain specialists refer patients who use opioids to a substance abuse clinic, seeking to disown the complications of problems such as opioid use disorder (OUD) even though pain remains a pressing concern for the person who attended the appointment hoping for relief. In addition, those in settings such as primary care or community-based clinics regularly encounter patients who are struggling with both pain and opioid issues. These practitioners may feel particularly underprepared to provide useful interventions given their usual lack of time and their focus on generalist training. And sadly, research indicates that those with substance use disorders are less likely than others to receive effective pain treatment (Rupp & Delaney, 2004).

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WHY THIS BOOK?

The purpose of this book is to offer health care providers a contextual framework and implementable, integrated strategies to assist those individuals managing both chronic pain and opioids. In the literature, these issues are often addressed separately; however, that separation does not reflect the realities of clinical practice. It is now commonplace to encounter patients who have longstanding chronic pain and are in the process of addressing their opioid use. Some may be tapering opioids slowly with few negative effects and may be pleased with the decrease in medication use. Others may have been urged by a prescriber to reduce their opioids and may feel highly resistant to the idea, even in the absence of significant analgesic or functional benefit. Still others may be self-motivated to decrease opioids but fearful about how such a change might impact their pain or their lives.

The situation is complicated for both patient and health care provider and is often accompanied by a multifaceted clinical picture that includes medical and psychiatric comorbidities as the backdrop. Given that, it is both efficient and sensible to integrate discussions and guidance regarding how all the relevant pieces fit together. Conjointly discussing pain and opioid management from an integrated behavioral standpoint is useful as it embraces a whole-person approach to care, allows cross-cutting strategies to be applied, and maximizes the reduction of suffering. One of the limitations of currently supported behavioral treatment options is that they do not explicitly incorporate considerations related to the use of opioids. For many who need assistance, particularly those with high-impact pain, these issues are inextricably linked and should be treated as such, hence the effort to do just that.

This is a book on better treatment for those individuals with chronic pain who are at one of the many points along the opioid journey: considering deprescribing, in the process of opioid tapering, having recently discontinued opioids, or using opioids effectively for pain, among others. They are suffering from the effects of chronic pain, and opioids have been an important or at least a familiar part of life. We (the authors) are experts in pain management and have seen firsthand the utility of integrating effective clinical communication and behavioral strategies related to these issues. We are not addictionologists or addiction therapists, but we have been exposed to far more challenges regarding opioid use, misuse, addiction, and dependence than anticipated because we came of age in the current health care landscape. Learning to weave together the clinical approaches for both pain and opioid concerns is part of the art of optimizing treatment.

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This book is not aimed specifically at opioid tapering. Whether or not to taper opioids is a decision that is made ultimately between the prescribing medical provider and the person with pain. With the patient's consent, loved ones should be involved in the process because they are affected by the decision, can be helped by education and expectations around deprescribing, and are instrumental in whether decreasing is successful or not. Health care providers, such as nurses, psychologists, and other members of the pain treatment team, can provide information and support for individuals tapering at every stage; integrated pain and opioid strategies for optimizing these interactions are thus useful to all parties. If indicated, reductions in opioid use should be planned thoughtfully and in a collaborative manner. Unless there is an urgent safety need, it is appropriate for an individual to taper opioids slowly on an outpatient basis, check in regularly, and monitor effects on functioning.

This book is also not about OUD. It is critically important to evaluate every person who uses opioids and determine if they have OUD. While most will not, those who do or likely do must be connected with a clinical pathway where they can access appropriate, evidence-based options for OUD such as medication-assisted treatment (MAT). Ideally, access to MAT is without significant barriers, and there is an established process to facilitate a "warm handoff." Once a mechanism for addressing opioid dependence is implemented, ways to behaviorally manage chronic pain and familiar desires for opioids are likely to emerge. The strategies outlined here would likely be helpful for these individuals as well, in conjunction with other indicated treatments for substance use such as addiction-focused counseling.

Patients who are balancing pain and opioid use are prevalent across the spectrum of health care services and are treated by individuals from various disciplines in a range of settings. The approaches in this book, therefore, are intended to assist any practitioner who can be helped by better understanding the population, improving rapport and engagement, and implementing useful treatment strategies. It has been said many times that pain is a team sport—it is best managed not by physicians alone but by a group of multidisciplinary providers. To provide the best care, this book can be used by a range of those individuals, including but not limited to

- behavioral health clinicians (e.g., psychologists, social workers, counselors): Those in behavioral health must take a leadership role in addressing how all aspects of patients' lives impact and are impacted by chronic pain and opioid use. They can help empower patients by providing tools for increased self-efficacy.

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- physicians and prescribing medical providers (e.g., MD, DO, advance practice nurse, PA): Pain is the most common presenting complaint for medical providers working in primary care settings and for many specialists. Their communication and input regarding the best approaches for pain and opioids is foundational and often holds much weight with patients.
- nurses: Nurses are often the front line to health care. Seen in primary and specialty care, they are gatekeepers to all things related to the patient's health. Their importance cannot be overestimated; it is, therefore, particularly critical for them to have the knowledge and skills to best assist this population.
- physical medicine and rehabilitation therapists: Physical, occupational, vocational, and recreational therapists as well as others interface routinely with this patient population and may feel underprepared. Their functional restoration focus leaves them well positioned to enhance their clinical effectiveness by adding helpful approaches.
- pharmacists: Clinical pharmacists are increasingly involved in pain management generally and in plans for prescribing opioids more specifically. They increasingly offer consultative assistance to providers and interact with patients in settings that range from the community pharmacy to the multidisciplinary hospital team.
- complementary and integrative health care professionals: Options such as chiropractic care, yoga, tai chi, acupuncture, and massage are increasingly in demand for this population. Practitioners can bolster their approaches by incorporating integrated pain and opioid strategies in a setting where patients are often comfortable and open.

OVERVIEW OF THIS BOOK

This book is divided into four parts. Part I, Foundations (Chapters 1–3), provides an overview of terminology and definitions, theoretical underpinnings, and empirical background necessary to understand the rationale and presentation of the approaches for pain and opioid management that follow. Many of the hesitations and fears that individuals possess can be assuaged with outcomes from others in similar positions; therefore, it is helpful for providers to be acquainted with the data. The Foundations

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section also explores the relationship between patient and provider, which is critical across health care conditions but deserves special attention among a clinical population that often feels misunderstood.

Following this important background information, the focus of the book shifts to clinical guidance, and the remaining three parts describe three phases of treatment. Although treatment is presented in a linear fashion, the reality of clinical care is that most patients move in a more fluid manner between topics or stages. Motivation, pain, stressors, and setbacks wax and wane, so health care providers should anticipate the need for ongoing assessment and flexibility over time.

Part II, Phase 1: Preparing for Change (Chapters 4 and 5), focuses on readying the patient for treatment. Particularly for those managing the difficulties that arise with chronic pain and opioid use, a proper evaluation to identify the presence of OUD is critical. Exploring past experiences and potential resistances to behavioral treatment and possible changes in opioid regimen must be handled with openness and directness.

Part III, Phase 2: Engaging in Strategies (Chapters 6–9), is about involving the patient in making behavioral changes by using the collaborative development of goals and a pathway for treatment. Specific integrated approaches are introduced, with clinical examples provided. These strategies will help with both pain and the anxieties that surface when one is managing opioids. This section also elucidates how to troubleshoot issues with implementation of skills and how to address potential symptoms that arise during treatment.

Part IV, Phase 3: Maintaining Gains (Chapters 10–12), focuses on maintenance of gains. While many patients are able to make changes, sustaining change over the long term can be the greatest challenge. This section of the book includes information about how to develop a concrete plan to guide behavior, establish realistic expectations for the future, and optimize resources to stay on track and minimize setbacks.

For all three phases, we illustrate concepts using a fictional patient named Jim. In sections labeled Clinical Conundrum, we describe Jim's challenges and strengths and present a dialogue between Jim and his health care provider. Jim is first introduced in Chapter 4, and he reappears in subsequent chapters to demonstrate common concerns and reactions from patients as well as sample responses for providers. As Jim progresses through treatment, readers are introduced to recommended techniques appropriate to the context and stage of change. These "Clinical Conundrum" sections are important learning tools as providers consider how to use an approach with real patients.

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LANGUAGE CHOICES

A note about terminology is in order. The words that we choose when discussing health conditions can be powerful and make an impact in positive or negative directions. This can be especially true when writing or speaking about topics that may be inherently sensitive, such as substance use. Stating that someone is an "opioid abuser," for example, sounds pejorative and blaming; however, a "person with an opioid use disorder" shifts the focus to the behavior and away from the individual, and this shift can be helpful (Kelly et al., 2010). Furthermore, a term such as "opioid misuse" may have a better connotation when interacting with patients and may lead to improved communication. When characterized as a "drug seeker" during a visit to the doctor, many patients feel they have been reduced to a stereotype, not listened to as a human being who is in great discomfort. Although far less often acknowledged, this situation also frequently occurs with individuals experiencing chronic pain. Describing someone in the health care system as a "pain patient" often implies unfavorable qualities about the individual—that they may be challenging to interact with or difficult to please. Providers may form prejudgments that set the stage for suboptimal clinical interactions. For this reason, we use the terms "people" and "individuals" when discussing those who are managing chronic pain and opioids. Their health conditions are not who they are but rather are one of many factors contributing to their whole self.

Along that line, perhaps the greatest challenge with this book was determining the best way to reference individuals' opioid use. Because this book is not intended exclusively for those who are tapering opioids but rather for a broader group at various stages with opioids, it was not possible to label the general population accurately with a simplistic term. Because our focus is not on those with OUD explicitly, we largely avoid this topic. And while we maintain the connection between chronic pain and opioids for consistent integration in treatment, we do not assume that everyone is misusing or taking medications other than as prescribed. Misuse may be an issue for some patients, but the focus of the book is an empathic, active, wellness-based approach to clinical interactions for a broad spectrum of clinical presentations.