The Gentle Art of Saying "No": How to Establish Appropriate Boundaries with Chronic Pain Patients

DAVID COSIO, PHD, ABPP

Biography

David Cosio, PhD, 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.

DISCLAIMER:

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

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Objectives

- Describe patient-provider shared responsibility while prescribing pain medications
- Explain the model of collaborative care and the challenges of setting patient boundaries
- Explain the steps of resolution
- Discuss a plan on setting boundaries in example patient cases

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The Pendulum Swings…

- Deemed a human right
- Believe entitled to opioids
- Providers feel pressured
- Reinforces patient's beliefs and reliance on medication

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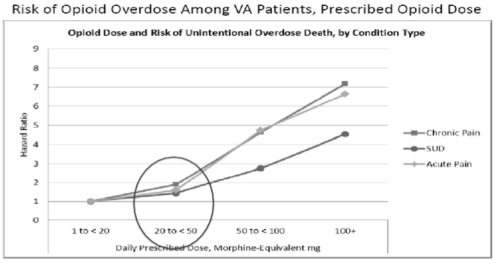
Risk of Opioid Overdoses

- Side effects/addiction
- Dramatic rise in opioid misuse and deaths from OD
- High profile deaths like Heath Ledger and Prince
- Identified by CDC as "public health epidemic"
- CDC released guidelines in March 18, 2016

Risk of Opioid Overdose Among VA Patients, Prescribed Opioid Dose



From Bohnert, Valenstein, Bair et al., 2011 *JAMA*

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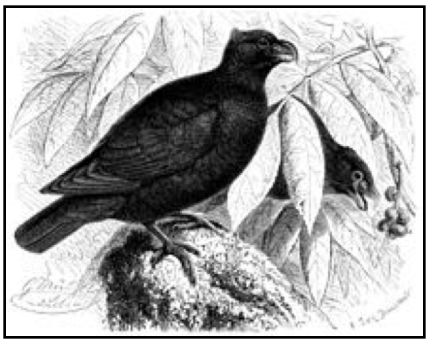
The Current Evidence

- Research results presented are disheartening
- Best evidence for pain reduction averages around 30-60%
- Clinical trials have indicated comparable efficacy of numerous diverse treatments
- *Manumea* is a cousin to Dodo bird used in reference to "Dodo bird effect"



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PM&R Common Factors Model

- Using models developed in other professions to inform inquiry in another field is appropriate and there is some precedence in the literature, specifically in physical medicine and rehabilitation (Miciak, Gross, & Joyce, 2011)

Table 2 Proposed common factors in physical therapy identified by the authors[a]

Superordinate common factor category	*Individual commonalities*
Change processes	Teaching and educating; provision of plausible diagnosis, treatment plan and self-management strategies; collaboration/goal setting; provision of positive feedback to client
Therapist qualities	Professional; knowledgeable and skilled; warm; empathetic; therapist pain perceptions and beliefs
Relationship elements	Quality of patient–therapist interaction (general); therapist listens; therapist provides explanations; engagement or time spent with client
Treatment structures	Use of techniques
Client characteristics	Positive expectation about specific treatment; psychosocial factors; perceived helplessness

[a]Authors' interpretation of a proposed common factors table for physical therapy from a portion of the literature (31, 40, 42–48) reviewed for this article. Based on the superordinate categories of common factors identified by Grencavage and Norcross (11).

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The "Dodo Bird" Effect

- References to concept of "common factors" in psychotherapy began as early as 1936 (Rosenzweig, 1936)
- At that time, research studies were concluding that all psychotherapies were effective and "all must have prizes," a verdict later termed "Dodo bird effect" which references a scene from *Alice's Adventures in Wonderland* (Wampold et al., 1997)

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Common Factors

- In 1952, Eysenck announced his refutation, "psychotherapy does not lead to improved patient outcomes," and research into efficacy of psychotherapy witnessed a resurgence
- Several meta-analyses illustrated absolute efficacy of psychotherapy (Andrews & Harvey, 1981; Landman & Dawes, 1982; Shapiro & Shapiro, 1982; Smith & Glass, 1977; Wampold et al., 1997)
- Two important findings have been noted from those analyses:

1. **Improved research methods did not increase the effects found**
2. **Effect sizes were comparable across all treatments**

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Specific vs Nonspecific Effects

- These conclusions led to distinction of two possible mechanisms of psychotherapeutic change, specific versus nonspecific effects
- Specific effects were associated with unique interventions to certain therapy approaches
- Nonspecific effects were linked with contextual factors of clinical encounter
- Evidence from systematic reviews of diverse psychotherapy interventions indicate that factors common across therapies contribute more to treatment outcomes than specific effects (Frank & Frank, 1991; Wampold, 2001)

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Common Factors

- Meta-analytic studies summarize psychotherapy outcome research and reduced the factors into four areas:
  - client factors (explaining 40% of the variance in outcomes)
  - therapeutic relationship factors (30%)
  - expectancy/placebo/hope (15%)
  - techniques/models (15%) (Hubble, Duncan, & Miller, 1999; Lambert, 1992)
- The *Great Psychotherapy Debate* (Wampold, 2001) concluded that nonspecific effects were responsible for more than **4x** amount of variance in treatment outcomes across various interventions

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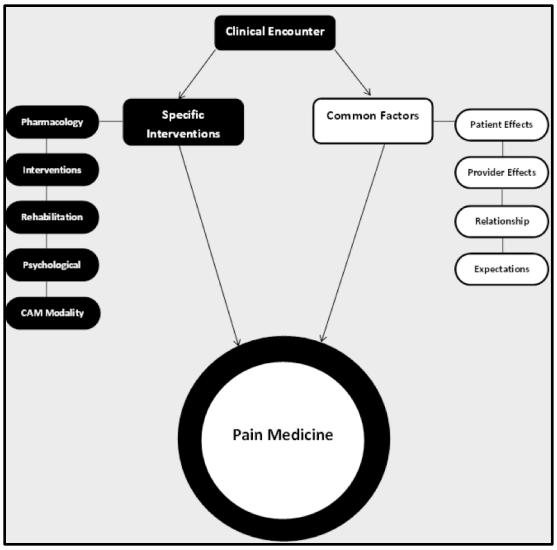
Common Factors in Pain Medicine



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Patient Factors in Pain Research

- In summarizing findings from the various studies, it would appear that treatment outcomes were better when the patient:
  - Was employed, which affects remission
  - Had high treatment outcome expectations
  - Was resilient and remained positive
  - Was engaged in activities that were purposeful
  - Was motivated to manage pain
  - Had an internal locus of control
  - Felt they had control over their pain
  - Perceived having social support
  - Believed in god or a spiritual power greater than themselves
  - Did not experience any recent/daily life stressors
  - Had positive beliefs and used coping strategies
  - Had an increased readiness for change

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Why Are Patients Deemed Difficult?

- Mistreated, robbed, or ignored
- Personality conflicts
- Social or financial problems
- Lack of trust, information, or communication
- Cultural differences/language barrier
- Cognitive impairment
- Severe mental health/addiction concerns
- Secondary gain
- System concerns: what happened today?
- Negative drug interaction

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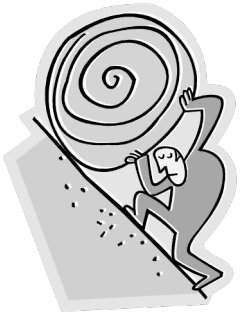
"There are no difficult patients, just patients with difficulties."



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Therapeutic Relationship Factors

- In summarizing findings from many examinations, it would appear that:
  - Provider empathy plays a crucial role in pain treatment
  - Providers who are warm are more effective
  - Patients are more satisfied when they perceive they are respected by providers
  - Patient suffering may be affected by acknowledgement of genuineness of pain
  - Patient need to reframe treatment as acceptance of chronic pain
  - Patient encouragement and instruction decreases pain and increases satisfaction
  - The communication process influences self-management of pain
  - Patient-provider relationship is significantly associated with outcome

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Common Provider Failures

- Use jargon and avoid certain topics
- Too much information and assume understanding
- Patient afraid to assert themselves
- Make jokes and ignore how impacts patient
- Fail to explain a teaching hospital and/or clinic's functioning
- Provider feels like a police officer, judge, or deal-maker

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Expectancy Factors

- In summarizing the results from numerous investigations, it would appear that treatment outcomes were enhanced when:
  - Patients' expect and believe treatment is potentially beneficial
  - Providers consider how placebo effects and regression to the mean improve outcomes
  - Providers consider the patient's potential to be noncompliant and relapse
  - Patients are optimistic, have hope, and/or accept their pain
  - Patients feel providers believe their pain is credible
- Several common themes that are aligned with the pain medicine environment began to appear and reoccur throughout the search, including:
  - Sociocultural
  - Ethical/legal

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Provider Relationship Expectations

Patient is expected by provider to:

- Be open
- Honest
- Obedient
- Motivated to get better
- Display gratitude
- Display pleasure at improvement

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Patient Relationship Expectations

Provider is expected by patient to:

- Be thoughtful
- Listen
- Be empathic
- Be nonjudgmental
- Do no harm
- Be competent

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Patient-Provider Shared Responsibility

- Model of collaborative care
- Known as “working alliance”
- Originated in MH (Greencavage & Norcross, 1990)
- Validated by strong research support

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Patient-Provider Shared Responsibility (cont'd)

- Patients with rewarding relationships have:
  - Better outcomes
  - Less likely to seek assistance from other sources
  - Reduces the risk of conflicting treatment plans
  - Reduces risk of further confusion

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Continuation of Care Plans

- Heightened interest in pain management
- NEED for appropriate boundary setting more apparent
- NEED for consistency of self-management message throughout disciplines

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Gentle Art of Saying "NO"

- Sometimes what the patient wants may NOT be what they need
- Saying "NO" may be the therapy!!!
- Case study

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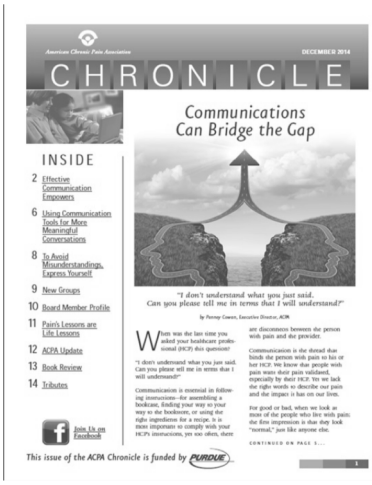
Provider Training

- Communication is most important life skill
- Don't usually put effort into this skill set
- 5 essential components:

1. Really listen
2. Express empathy
3. Be concise
4. Ask questions and reflect
5. Watch your body language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CHRONICLE

Communications Can Bridge the Gap

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"I don't understand what you just said. Can you please tell me in terms that I will understand?"

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Provider Training (cont'd)

- Communication training has been beneficial in improving relationship

- Essential elements of healthy relationship:
  - Compassion
  - Clear expectations, or *established boundaries*
  - Provider giving adequate explanations
  - Patient being active participant
  - Patient part of decision making

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Boundary Setting

Boundaries:

- Simple rules or limits
- Created by individuals
- Identify reasonable, safe, permissible ways for others to behave around them
- Determine how they'll respond when someone oversteps these boundaries
- Pain management requires appropriate boundaries
- Hard for providers to identify potential ruptures

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Ask Yourself the Following:

- Is it hard for you to say no or yes?
- Are you ok when others say no to you?
- Do you take on other people's problems or pain?
- Do you experience other people's problems or pain?
- Do you share personal information quickly or slowly?
- Is it hard for you to share anything?
- Do you tell people in your life what you want, what you need, and how you feel?
- Are you able to ask for help when you need it?
- Is someone hurting or disrespecting you?

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Difficulty Setting Boundaries?

- Boundary setting requires lots of thought and practice
- Providers learn little about this in clinical training
- To master skill, recognize:
  - Boundaries are not a threat
  - Not an attempt to control others' behaviors
  - Setting limits improves relationships with patients

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Practice Setting Boundaries

1. **Name** or describe the behavior that is not acceptable to you
2. **Express** what you need or expect from the other person
3. **Decide** what you will do if he or she does not respect the boundaries you've established
4. **Validate** your actions by recognizing that setting boundaries is important work and that your rights are important

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Popular Media Example

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Boundaries are NOT Comfortable

Providers feel uncomfortable during process

- When reasonable limits placed
- Continue to step beyond those limits
- Review what conduct is expected from patient
- Maintain boundary
- Review precise actions can expect from staff
- Be consistent with message
- Remember Step 4…setting boundaries is important work
- Remember saying "NO" is the appropriate treatment!!!

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Boundary Setting Guidelines

- Establish boundaries or restrictions early on
- Be consistent and document
- Use policy/procedures as backup
- Review opioid pain agreement
- Use other tools available

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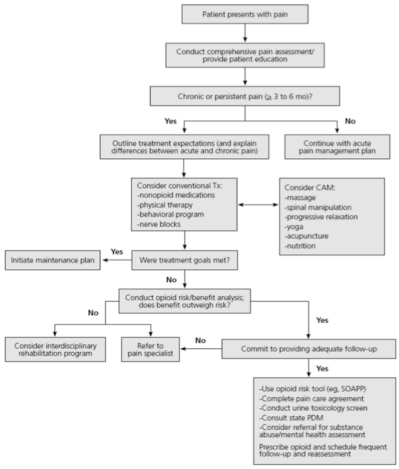
Use Other Tools Available

- Pain education school
- Random urine tox screens
- Prescription state monitoring
- Opioid risk tools (SOAPP)
- Use a “decision tree”



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Handling Patient Refusals

- It is the patient’s decision and right – they should take responsibility to make choices/recommendations available
- Providers are NOT obligated to provide opioids
- Providers ARE obligated to provide the best level of clinical care—1961 Single Convention on Narcotic Drugs
- Goals are to maximize safety and minimize risk for patient and community
- Providers should avoid making decisions based on emotions and not facts

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Case Study #1

- Patient comes to your clinic as a walk-in and is reporting lost or stolen medications.

Name: Walk-in and reporting stolen medications

Express: Patient's shared responsibility for medication safety

Decide: Will not refill without police report

Validate: Consult local paper or prescription state monitoring

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Case Study #2

- Patient urgently calls you with increased pain and then shows up to your clinic for an unscheduled appointment and asking for an early refill.

Name: Show up unscheduled with increased pain

Express: Emergent pain treated in ED or Urgent Care

Decide: Unscheduled visits should NOT be used for opioid increases

Validate: Patients deserve to have a full visit

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Case Study #3

- Patient is upset and is making SI/HI threats after being told d/c opiates at this time.

Name: Patient is making SI/HI threats

Express: Concerns about patient, provider, and community safety

Decide: Call for police backup/refer to ED/refer to MH

Validate: Consult/debrief with other providers for support

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