Trauma Informed Communication
Motivational Interviewing and Persistent Pain

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Objectives

• Identify the relationship between ACES, trauma and persistent pain.
• Outline how motivational interviewing is a trauma-informed intervention
• Highlight doable skills for a busy clinician.
• Identify how these skills can be consolidated into a busy office visit.
Persistent Pain & Trauma
Backstory:

- Mid-1980s, Felitti was running an obesity program through KP
  - 1985, became concerned with attrition rate.
  - Conducted 286 face-to-face interviews with patients to discuss
    - Identified significant prevalence of childhood trauma w/ eating identified as a shield/protective factor.
    - 1990 results from interview were presented at National Obesity Conference.
    - Thesis: “Certain of our intractable public health problems had root causes hidden by shame, y secrecy and by social taboos against exploring certain areas of life experience.”

- Initiated study with CDC
  - KP Department of Preventative Medicine
ACES Study

- 17,337 total participants.
  - 54% women, n = 9,367
  - 46% men, n = 7,970

- Mean age = 56 years

- 75% percent white

- 39% were college graduates
- 36% had some college education,
- 18% were high school graduates
- 7% had not graduated from high school
## Prevalence of Trauma

### Neglect

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>15%</td>
</tr>
<tr>
<td>Physical</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Abuse

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>11%</td>
</tr>
<tr>
<td>Physical</td>
<td>28%</td>
</tr>
<tr>
<td>Sexual</td>
<td>21%</td>
</tr>
</tbody>
</table>

### Household Dysfunction

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Substance Abuse</td>
<td>27%</td>
</tr>
<tr>
<td>Parental Separation/Divorce</td>
<td>23%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>17%</td>
</tr>
<tr>
<td>Battered Mother</td>
<td>13%</td>
</tr>
<tr>
<td>Criminal behavior</td>
<td>6%</td>
</tr>
</tbody>
</table>
Prevalence:

• 64% = Answered ‘yes’ to 1 or more categories.
• 87% = Answered ‘yes’ to 1 had at least 1 additional category endorsed.
• 40% = At least 2
• 12.5% = 4+
• 10% = 5+

• Only 33% had a score of Zero.
So What...

• The ACE Score has a graded relationship to numerous health and social outcomes.
  • Ace = 4; 2x as likely to be dx’d with cancer as someone with an ACE = 0
  • 20% increased likelihood of hospitalization in adulthood for an autoimmune disease/ACE score.
  • ACE = 4; 460% more likely to have depression than s/o w/ ACE = 0
  • ACE = 6; shortened lifespan by ~20years.

• One of the best predictors for high utilization of medical services.
Co-Occurring?

• Controlled for engaging in maladaptive coping strategies
  • Continued with higher risk of developing a chronic medical condition.
    • E.g. ACE of 7+ w/ no tobacco use, not overweight, not diabetic, did not have high cholesterol
      • 360% higher risk of heart disease than those with an ACE of 0.
ACES and Persistent Pain

• Brief Summary: ACES have a profound effect on subsequent health and psychological functioning.
  • Alters basic biological and neural processes during development
  
  (Heim & Nemeroff, 2002; Nemeroff, 2016)

• Alters physiological and behavioral responses to subsequent stress
  • Suspected: dysregulation of the Hypothalamic-pituitary-adrenal (HPA) axis and autoimmune system
  • May underlie risk for mood and anxiety disorders as well as pain related conditions.

  (Sachs-Ericsson, Sheffler, Stanley, Piazza, Preacher, 2017)
ACES and Persistent Pain

• Established association between retrospective reports of childhood abuse experiences and adult pain-related medical conditions

• A relatively high proportion of patients with chronic pain-related medical conditions have a history of childhood physical or sexual abuse
  (Bailey, Freedenfeld, Kiser, & Gatchel, 2003; Davis et al., 2005)

• Individuals from the community reporting pain-related medical conditions were more likely to have been abused or neglected than individuals not reporting pain-related conditions
  (Davis et al., 2005)
ACES and Persistent Pain

• 3+ ACEs are associated with an increased prevalence of all medical disorders, including pain-related conditions.
  • (Raphael, Chandler, & Ciccone, 2004)

• Strong association between ACEs, mood and anxiety disorders, and pain-related medical conditions
  • (Raphael & Widom, 2011; Scott et al., 2011; Walsh et al., 2007)

• ACEs were associated with early-onset anxiety and mood disorders and subsequent pain-related medical conditions.
  • (Scott et al., 2011)
Childhood → Adult Health

• individuals exposed to ACEs are more likely to experience subsequent negative life events in adulthood.
  
    • (Liu, Choi, Boland, Mastin, & Alloy, 2013)

• Individuals who experienced earlier childhood sexual or physical abuse appear to have a more intense response to stressors
  
    • (Cromer & Sachs-Ericsson, 2006),

• The “sensitization” hypothesis = prior exposure to any trauma sensitizes an individuals tendency to respond more intensely to subsequent stressors.
  
    • (Resnick, Yehuda, Pitman, & Foy, 1995; Yehuda et al., 1995)
Result:

- Biological hardwiring
- Decreased resiliency
- Limited coping strategies
- Increased sensitivity = more intense response to subsequent stressors
- Increased likelihood to develop chronic medical disease and pain-related conditions.
Our stress response creates chemical changes that cause pain.

- Pain
- Stress Response
- Release of Inflammatory Chemicals
- Quieting Stress Response
- Anti-Inflammatory Chemicals
- Pain
- Sleep
John Smith

- 57yo European American Male
- Referred for chronic pain (face, neck and back), migraines and depression
- Hx of work related injury, full disability (~35yo)
- Tendency towards high-burden on primary care team
  - Multiple phone calls/long rambling mychart messages, extended visits, difficulty tracking
  - Goal of alternate strategies for pain management and mood.
John Smith

- Extensive history of childhood trauma
  - Physical abuse
    - (infancy, childhood, adolescence and physical assaults into adulthood)
  - Emotional abuse
  - Sexual abuse
  - Emotional and physical neglect
  - Hx of IPV within the home
  - Brief parental separation
  - Father with Alcohol Use Disorder
  - Mother with known mental health dxs

- Later life, ongoing injury/abuse
  - Work related injury leading to disability
    - Head, neck and back injury; TBI
  - Physical, emotional abuse by wife
    - Ongoing
  - Concern of financial abuse
  - Intentionally isolated
    - Only place he feels safe is with his primary care team.

ACES = 8

Ongoing re-experiencing
Communication and Trauma
Trauma and Communication

• Conversations about change are hard
  • Tend to fall in to 3 categories
    • Directing
    • Following
    • Guiding
Directing and the Righting Reflex

• The Righting Reflex
  • As providers, actively attempt to ‘fix’ problems.
    • Born out of compassion.
  • Reduces likelihood of patient change.
  • Fails to consider the possibility of ambivalence.

• Ambivalence
  • under pressure results in a predictable response = pushback and discord.

• A lot of us are trained to be directive.
  • The righting reflex and trauma = pushing patients, triggering distress
Triggering Discord

• Things we as providers do that increase discord:
  • Trying to convince patients they have a problem.
  • Arguing for benefits of change
  • Telling patients how to change
  • Warning patients of the consequences of not changing.

• High discord is activating for patients and decreases the likelihood of change.

How do we facilitate change and engaging discussion in a way that honors ambivalence and does not trigger trauma or discord?
Motivational Interviewing
Motivational Interviewing (MI)

• “A directive, patient-centered style for eliciting behavior change by helping patients to explore and resolve ambivalence.”

• 4 Domains of Philosophy:
  • Partnership
  • Acceptance
  • Compassion
  • Evocation

Core Domains

Partnership
Evocation
Acceptance
Compassion
Core Domains

- Absolute Worth
- Affirmation
- Acceptance
- Autonomy
- Accurate Empathy
Basic Premises of MI:

• People *don’t* change just because we want them to change.

• People talk themselves into changing, we don’t.

• People rarely change just because we tell them to change.
How does change happen?

• It does occur naturally
• It is influenced the interactions between people
• Empathy is a means of effecting change.
• Best predictor of change is confidence
  • Patient or Physician confidence that the patient will change
• Patients who say they are motivated to change, likely do.

Lussier & Richard, 2007
Ambivalence

- Is normal
- Occurs throughout the change process
- Reflects costs and benefits of change and status quo
- Is uncomfortable
- May become chronic – “stuck”
- Beware of Righting Reflex
- Resolved by patient
- Model change language by saying “and” instead of “yes, but”
Integrating MI into the Healthcare Visit
Four Guiding Principles of MI (RULE)

- R = Resist the Righting Reflex
- U = Understand the patient’s Motivations
- L = Listen to the patient
- E = Empower the patient
OARS +I

- Open-Ended questions
- Affirmation
- Reflective listening
- Summaries
- Information exchange

- Identification of the patient’s values and personal goals.
- Element of focusing – joining of patient and provider goals, helps to form specific agenda.
Exchanging Information

• Importance in engaging, focusing and evoking change.
• Mutual information sharing
  • Provider and patient expertise

• Keys:
  • Offer information, do not impose.
  • Do clients really want the information?
  • Ask permission.
  • Give space for disagreement.
  • Allow space for self-application of information.
  • Provide context.
  • Use client statements.
  • Give facts, not just opinions (in a patient friendly way).

Information and Psychoeducation is Key in Persistent Pain
Pain Education As A Treatment Intervention


Decrease in postoperative utilization of services (Adriaan Louw, PhD, PT, et SPINE Volume 39, #18)


Increase in mobility (Moseley and Hodges, Clin J Pain, 2004 Louw et al Physiotherapy J, 2011)
Rethinking Pain

Our stress response creates chemical changes that cause pain

Pain  ➔  Stress Response

Release of Inflammatory Chemicals

Quieting Stress Response

Anti-Inflammatory Chemicals

Pain  ➔  Sleep

providence.org/paintoolkit
Rethinking Pain

Understanding Your Pain Story

The Big Picture: Many Things Affect Your Pain

Below, circle the two things that represent some of the biggest part of your pain story:

- Understanding my brain and nervous system's role when I feel pain
- Doing things that I enjoy and spending time with people who help me feel good
- Managing stress and worry
- Getting up and moving around
- Getting the right amount of sleep, not too much or too little
- Eating a healthy diet
- Other:

providence.org/paintoolkit
10 Things You Need to Know if You Take Opioids

1. There are other ways to treat your pain that can make your life better. Safer, non-opioid medications can help many people return to a more active and more enjoyable life. We'll say more about that, but wanted to make that clear up front.

2. Opioids may harm more than they help. Opioids are very useful for relieving short-term pain from injuries or after having a surgery. Opioids are not a good option for ongoing pain. In fact, they might make you worse off.
   - In addition to the chance for addiction and overdose, opioids can cause:
     - Problems with breathing and sleep
     - Severe constipation
     - An upset stomach
     - Problems having sex
     - Itchy skin
     - Confusion and depression
     - Falls and broken bones

3. Painkillers may actually increase your pain. Ongoing use of pain medicine may actually make pain worse for many people. This condition, called opioid-induced hyperalgesia, causes more pain by making pain messages in the brain more intense.

4. Anyone can become addicted to opioids. Opioids are highly addictive and anyone can become addicted to them. You may have a greater chance of addiction if you have had a history of drug or alcohol problems or psychological trauma. Even people who do not become addicted are likely to build tolerance to the medication. This means you will need to take higher and higher amounts for the medication to work. Eventually, the amount of opioids you take is very unsafe.

5. Know the amount you are supposed to take. We know that taking higher amounts of opioids increases your chance of an overdose. At a high amount, even a small medication change can cause an overdose. That's why we call it an accidental overdose. Taking other medications—like benzodiazepines (Valium, Xanax, and Ativan)—can increase the chance of an accidental overdose. Some opioids are stronger than others, even when you take the same amount. To compare different opioid medications, we use a term called “morphine-equivalent dose” (MED). This tells us how much morphine your current medication is equal to.
   - In the state of Washington, the law requires a pain specialist to approve any prescription with an MED over 120. In Oregon, Providence Medical Group doctors are working closely with patients who are over 120 MED to a safer level.
Elicit “Change Talk”

- Change talk vs. Sustain talk (Miller & Rollnick, 2013)
- Facilitate patient statements of:
  - Advantages of new behavior
  - Disadvantages of status quo
  - Optimism about being able to engage in behavior
  - Intentions to engage in behavior or change
- Persons become more committed to doing what they actually say
Eliciting Change Talk

• *In what ways would it be good for you to ... ?*
• *If you did decide to ... how would you do it?*
• *What would be the good things about ... ?*
• *Why would you want to ... ?*
• *The balance: What are the good things about ... and what are the not so good things?*
Change Talk

• Change your language
  • From Negative/Passive to Positive/Active words
    • Suffers from to struggles with
    • Refused to take to decided against
    • Didn’t keep appointment to was unable to attend
    • Not compliant with to had not seen value of
    • Chronic Pain to Persistent Pain
    • Managing pain to Changing your pain experience.

• Positively framed messages may be more effective than negatively framed messages when discussing health promotion and wellness (Leffingwell, et al, 2007)
Responding to Change Talk

- When you hear change talk, **Reflect it** – Restate it back to the person
- Ask for examples/elaboration:
  - *When was the last time you were able to engage in a family activity?*
- Ask for more:
  - *What was that like? What other reasons do you have to change how we manage pain?*
- Affirm change talk – reinforce, encourage, support it
- When patient is ready - begin setting SMART goals
Reinforcing Change Talk

• “It sounds like a good idea.”
• “It sounds like that could work.”
• “You make a good point.”
• “I can see you gave this a lot of thought.”
• “It’s important for you to...”
FOCUS

- First Ask Permission
- Offer ideas
- Concise
- Use a menu
- Solicit what the patient thinks.

- Always begin and end with the patient.
What about John Smith?

- Close coordination: PCP, BHP, Psychiatry and PharmD,
- Education (bidirectional)
- Delicate dance with ambivalence,
- Identification of values and eliciting change behaviors.
- Menu of Options
  - Relaxation
  - Meditation
  - Pacing
  - Exercise
  - Taper options
  - Medication evaluation
- Slow, patient centered pacing
  - High levels of motivational interviewing, patient engagement and values based discussions.
  - Emphasis on his values and how we as a healthcare team could aid in moving him towards values-based living.