Behavioral Health: Techniques, Referrals, & Talking to Your Patients About Counseling

Sharon Hsu, Ph.D.
Psychologist
Pain Services
Swedish Medical Center

Disclosure Information

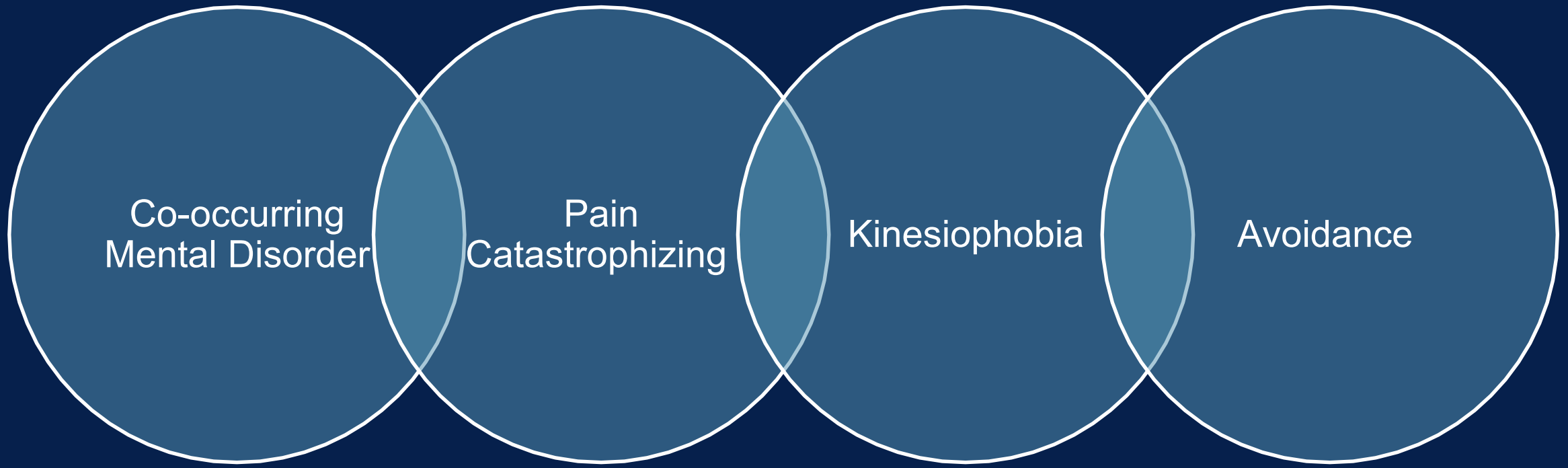
- Sharon Hsu, Ph.D.
  - No Disclosures.

Learning Objectives

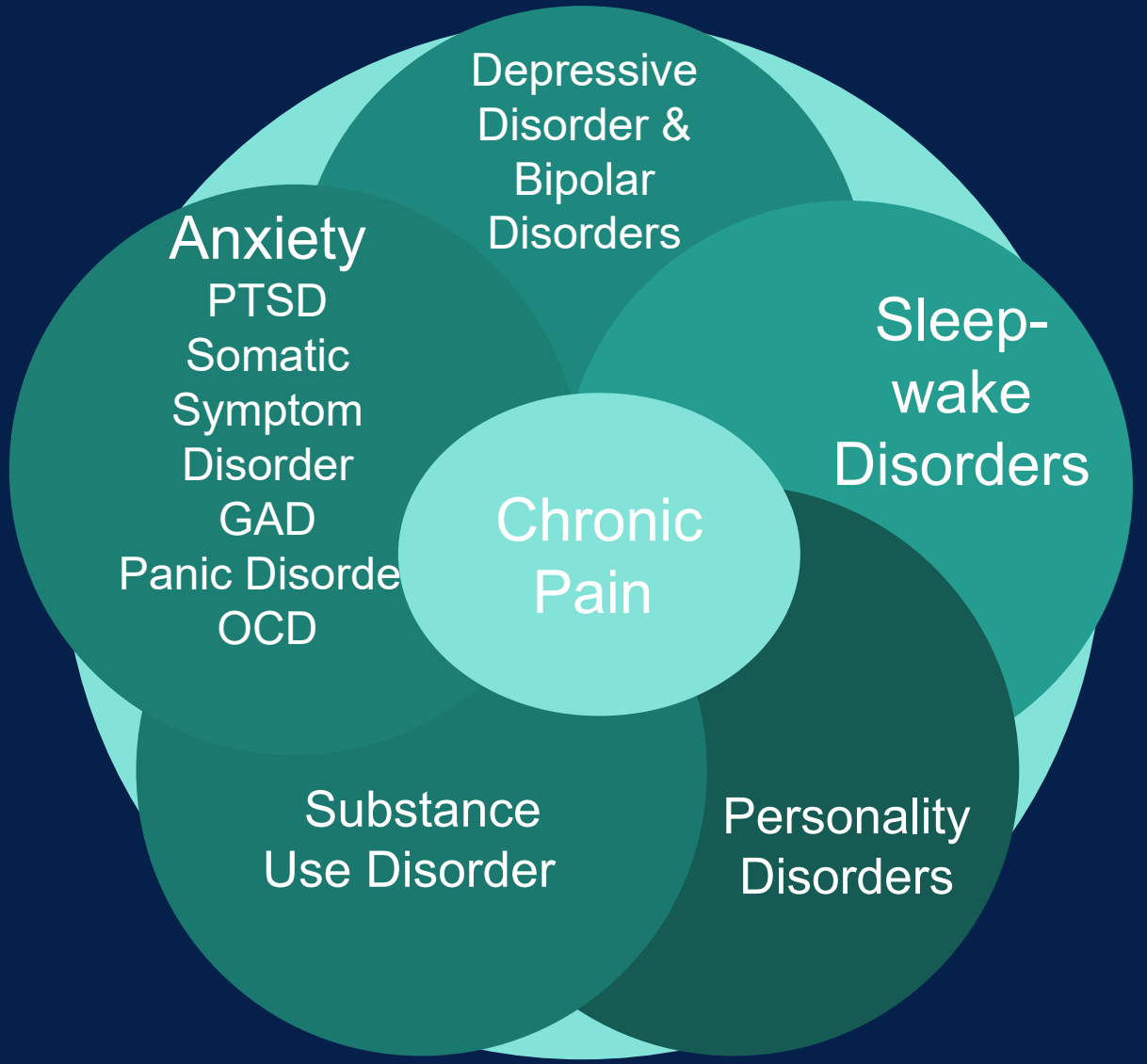
1. Know when to refer your patients to counseling. Be familiar with symptoms and signs.
2. Learn to use Motivational Interviewing to work with your patients with chronic pain, PTSD, and/or addiction.
3. Become familiar with resources for patient education and know where to refer your patients.
4. Identify evidence-based tools for self-care to address compassion fatigue and burnout.

Learning Objective 1

Signs and Symptoms to Consider



Chronic Pain & Co-occurring Mental Disorder



Elevated Prevalence of PTSD in Patients with Chronic Pain

- A current PTSD prevalence of **35%** was seen in a sample of chronic pain patients, compared to **3.5%** in the general population.
- In a study of patients with chronic low back pain, **51%** of the patients evidenced significant PTSD symptoms.
- Adult survivors of childhood abuse tend to be more at risk for developing certain types of chronic pain later in their lives.
  - The most common forms of chronic pain for survivors involve pain in the pelvis, lower back, face, and bladder; fibromyalgia; interstitial cystitis; and non-remitting whiplash syndromes.

(Asmundson et al., 1; Kessler et al., 2; Scaer et al., 3)
https://www.ptsd.va.gov/professional/assessment/screens/index.asp

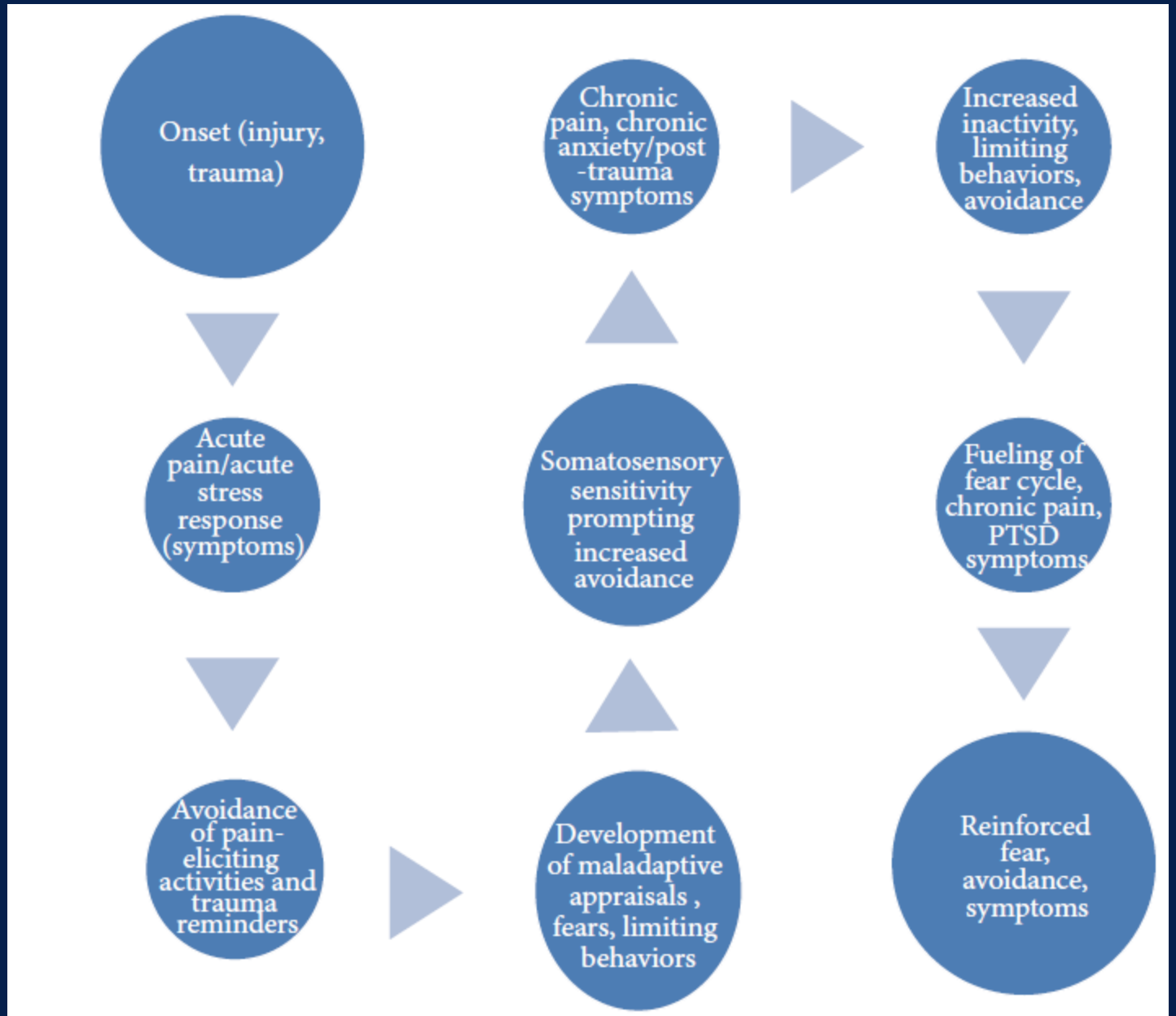
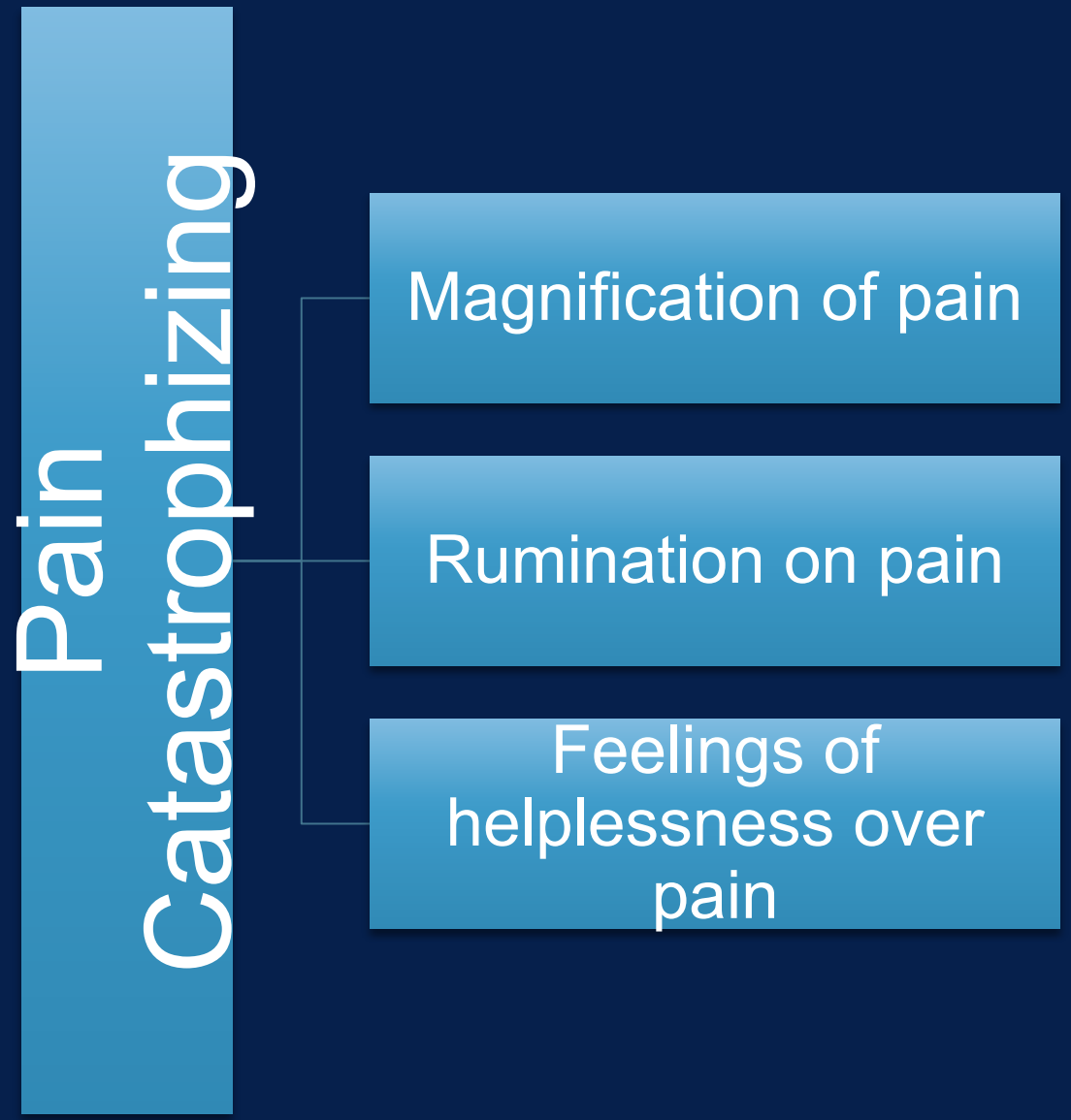


FIGURE 1: Comprehensive fear-avoidance cycle of chronic pain and PTSD.

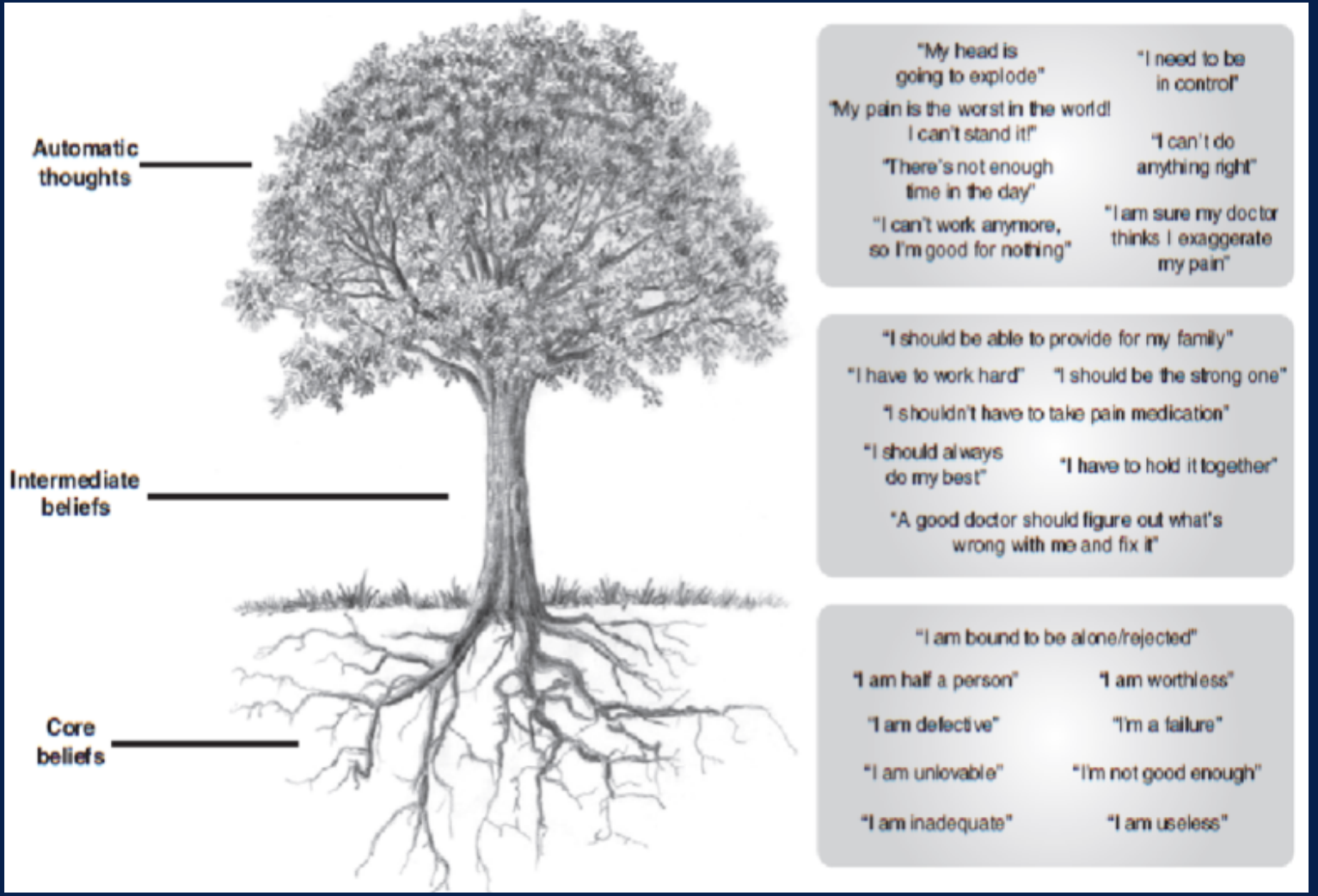
(Bosco et al., 4)



(Turk, 5)

http://sullivan-painresearch.mcgill.ca/pdf/pcs/PCSManual_English.pdf

Unhelpful Thinking Habits



(Day, 6)

Kinesiophobia and Avoidance

- Fear of movement; a state where an individual experiences excessive, irrational, and debilitating fear of physical movement and activity as a result of a feeling of susceptibility to painful injury or re-injury.
- Not understanding the difference between hurt and harm often leads to avoidance of activities and movement.
- Avoidance leads to physical deconditioning, low mood, relationship issues, and more.
- Not moving makes next attempt to engage in activity even more difficult and painful, reinforcing the fear, and increasing anxiety about moving again.

(Ishak et al., 7; Miller et al., 8)

Learning Objective 2

Applying Motivational Interviewing

- Practice a guiding rather than directing style.
- Develop strategies to elicit the patient's own motivation to change.
- Refine your listening skills and respond by encouraging change talk from the patient.

(Rollnick et al., 9)

Directing vs. Guiding

- The "righting reflex"
  - The automatic tendency of an organism to return to an upright position when it has been thrown off balance or placed in a supine position.
  - Tendency to identify a problem and solve it for the patient.
  - Problems
    - Patient-provider power dynamics
    - Arguing for change
    - Stop listening
    - Increase provider burnout

Directing vs. Guiding

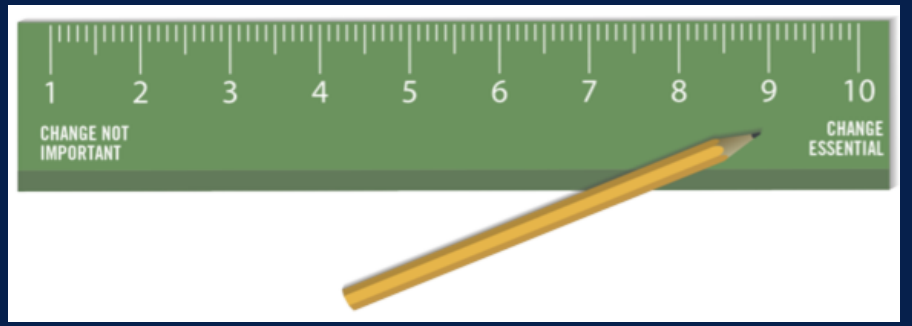
- Directing: *You didn't do any home exercise over the weekend. You were so motivated when you were in the clinic. You know not moving is just going to make pain worse! There is no way you can get around this simple fact.*

Directing vs. Guiding

- **Guiding:**
  - **Ask** open-ended questions- *What have you noticed about...*
  - **Listen** to understand patient's experience and **capture** their account: Y*ou really want to do the exercise. But you find yourself keep pushing it off. Before you know it, the weekend is over. Sounds like you were struggling with procrastination. This must be frustrating for you.*
  - **Asking permission** to provide information: *Sometimes patients have a hard time doing home exercise because they still have doubts about how helpful the exercise can be. Would it be helpful if we review pain education and discuss how it is connected to the home exercise?*

Strategies for Eliciting Motivation

- Agenda setting:
  - *Are you ready to focus on chronic pain or trauma? Or is there some other topic that you would prefer to talk about?*
- Pros and Cons:
  - *I want to understand your marijuana use from your perspective. Can I ask you what marijuana does for your pain, mood, and sleep?*
- Assessing importance and confidence
  - *How important is it for you to...*
  - *How confident do you feel about...*



Strategies for Eliciting Motivation

- Exchange information ("elicit-provide-elicit")
  - *Ok, can I check your understanding of the situation? What do you know about the risks of not moving when you have chronic pain? (Elicit understanding) Well, you are right that it can make movement harder, and people can become deconditioned. It also makes pain worse in the long run, unfortunately. (Provide information) How do you think this information applies to you? (Elicit pt's interpretation)*
- Making decisions
  - *It sounds like you really want to take less opioids, but you are struggling to imagine how you can do it. You are worried that you wouldn't be able to cope with pain. (Summarizing pt's situation)*

Respond to Patients' language Skillfully

Change Talk

Desire

- Want
- Wish
- Like

Ability

- Can
- Could
- Able

Need

- Need to
- Have to
- Must
- It is important to...

Reason

Change Talk

Commitment

- Will
- Intend to
- Going to

Activation

- Ready to
- Willing to

Taking steps

- Recent specific action towards change

Case Discussion

A young female patient with chronic pelvic pain and PTSD. PTSD stems from sexual assault occurred in her teens. She works full time. She is participating in the Functional Restoration program to receive interdisciplinary therapy for chronic pain.

"I can't sleep because of my nightmares. I have flashbacks during the day and this is really uncomfortable. I don't want to meditate. I know I need PTSD counseling. I have a reminder on my phone to call and make an appointment. I still haven't made the call yet. I think I don't want to face it."

Change Talk

"I can't sleep because of my nightmares. I have flashbacks during the day and this is really uncomfortable. I don't want to meditate. I know I need PTSD counseling. I have a reminder on my phone to call and make an appointment. I still haven't made the call yet. I think I don't want to face it."

Eliciting Chang Talk

Psychologist: *We have time in our session today. What if we make the call together?*

Patient: *No, not today. I am too scared. I'm not ready.*

Psychologist: *I can see how this is scary for you. What do you think you need in order to get ready for making this call?*

Patient: *I don't know...*

Psychologist: *Is it ok for us to spend some time exploring this today? (Agenda setting)*

Patient: *Sure. I think it would be helpful. I have set a deadline for myself. I want to make the call by the end of the month. There are 10 days left... (Change talk)*

Eliciting Change Talk

Psychologist: *So you still have some time left. (Listening)*

Patient: *Yes. I just can't bring myself to do it. I have an alarm that goes off everyday to remind me.*

Psychologist: *So you turned off the alarm when it goes off? How did you feel when it went off?*

Patient: *I feel very anxious. My heart is pounding so fast.*

Psychologist: *It is normal to feel anxious. I would feel the same if I were you. What do you think would happen when you make this call?*

Patient: *I think I would have to experience it again. I would have to tell them everything.*

Eliciting Change Talk

Psychologist: *That might be true once you start treatment. Even then, the therapist would work with you, go at a pace your feel comfortable. (Informing) Can I tell you what would happen at the intake? (Seeking permission) I can show you the interview questionnaire that is used to assess PTSD symptoms. Maybe this would help you feel more ready?*

Patient: *That sounds good. Let's take a look at it.*

<u>After reviewing the PTSD assessment</u>

Patient: *This is not as bad as I thought...I can see myself doing this. (Change talk)*

Psychologist: *Sounds like knowing what to expect helps. (Listening) Maybe you can fill out the questionnaire ahead of time. We can do it together if you'd like. When you call, you can review your response with the intake staff. This would probably make the phone call more manageable? (Making decisions)*

Patient: *Yes, I think so. But I would rather fill it out myself at home.*

Reflection

- Practicing MI takes time. Do you have time in your practice to learn this skill?
  - Consider participating in further training: https://motivationalinterviewing.org/
- Do you have time to implement this skill?
  - Identify patients who need more frequent visits.
  - Make changes to your workflow.
  - See fewer patients.

Useful Questions for Pain, Trauma, and Addiction

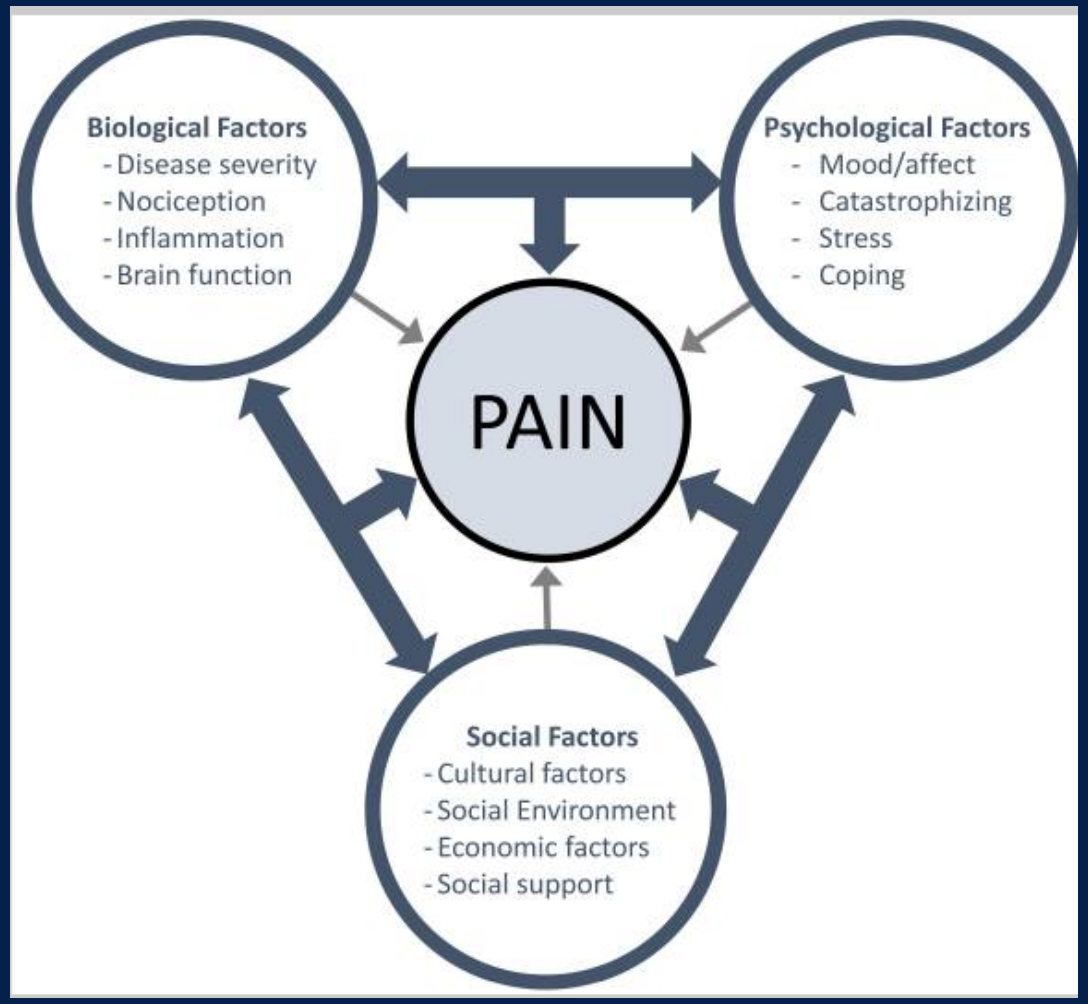
- What are your goals for pain management?
- What changes would you most like to talk about?
- What can't you do now because of...
- What are you losing because of...?
- What do you look forward to returning to if...improves?
- Where does this leave you now?

Learning Objective 3

Patient Education

- Biopsychosocial model
- Neuromatrix model
- Neuroplasicity
- Pain neuroscience education
- Chronic pain cycle
- Understanding PTSD
- Addiction education

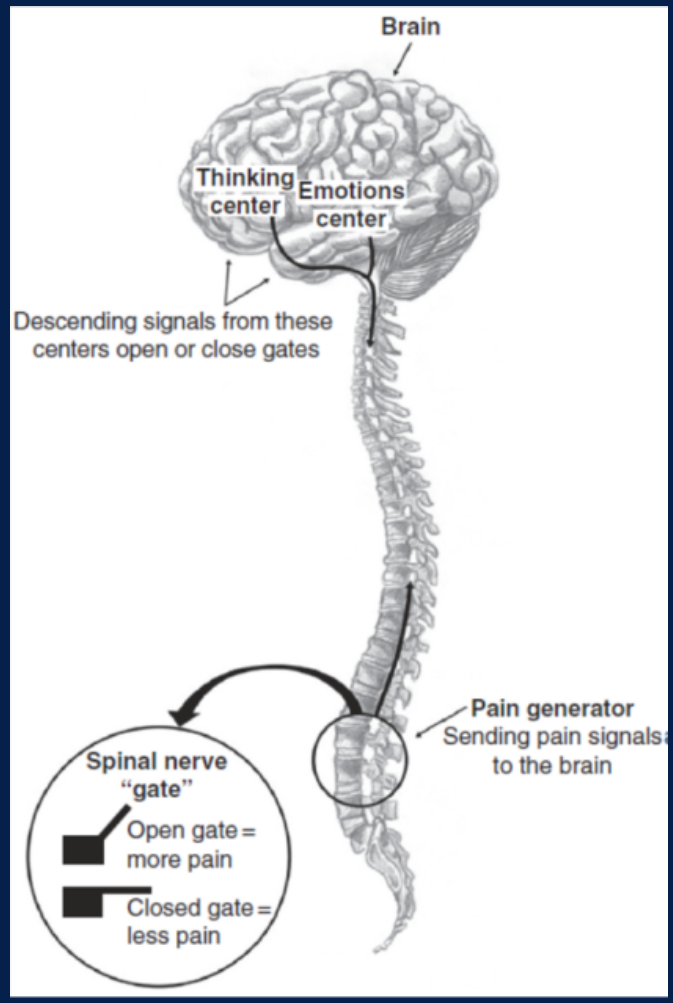
Biopsychosocial Model of Pain



(Fillingim, 10)

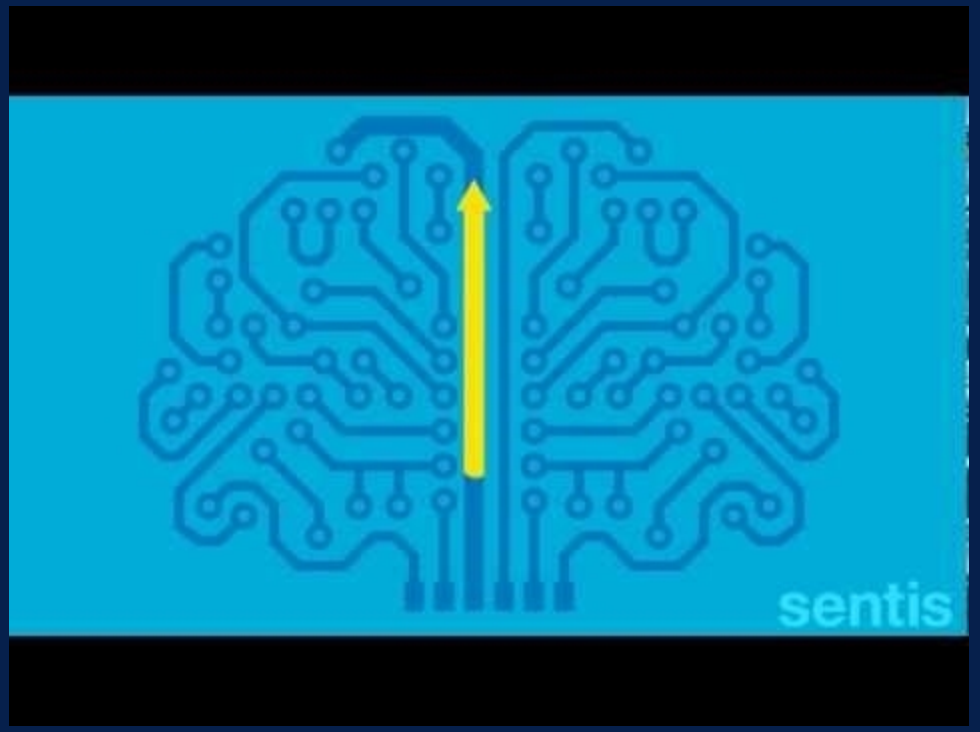
Neuromatrix Model

- Gate openers:
  - Overactivity and/or underactivity
  - Feeling depressed, anxious, angry, fearful, or other negative moods
  - Unhelpful, catastrophic, negative thoughts
  - Too much pain medicine over a long period of time
- Gate closers:
  - Meditation, yoga, physical activity
  - Mindfulness
  - Present-moment awareness
  - Pacing your activities without underdoing or overdoing



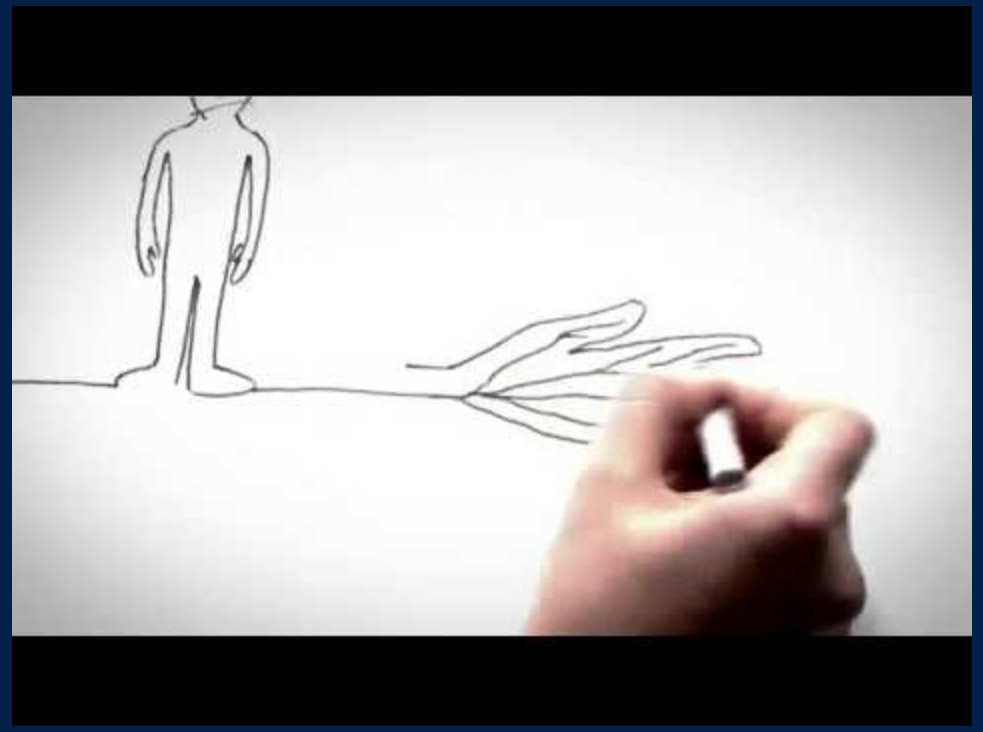
(Day, 6)

Neuroplasticity



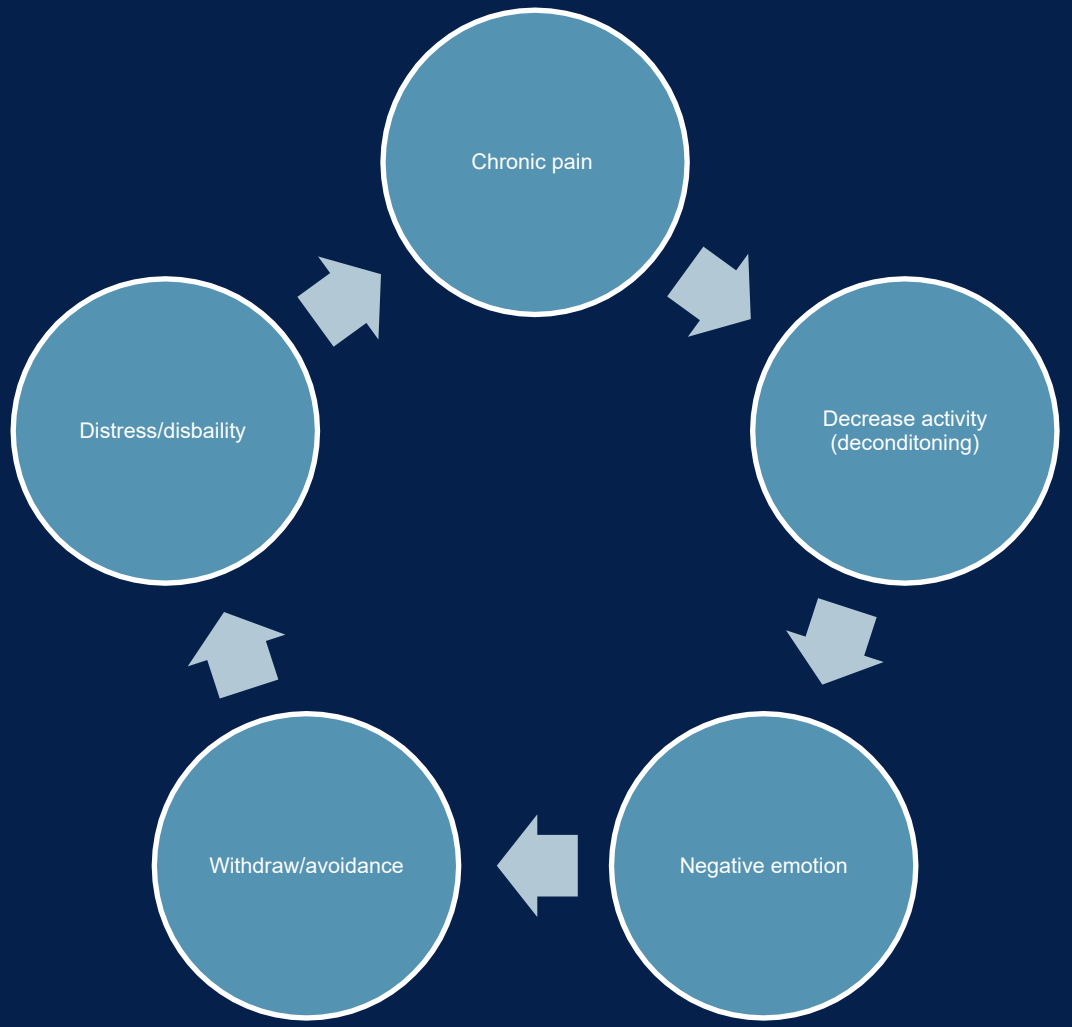
(Mansour et al., 11)
https://www.youtube.com/watch?v=ELpfYCZa87g&t=6s

Pain Neuroscience Education



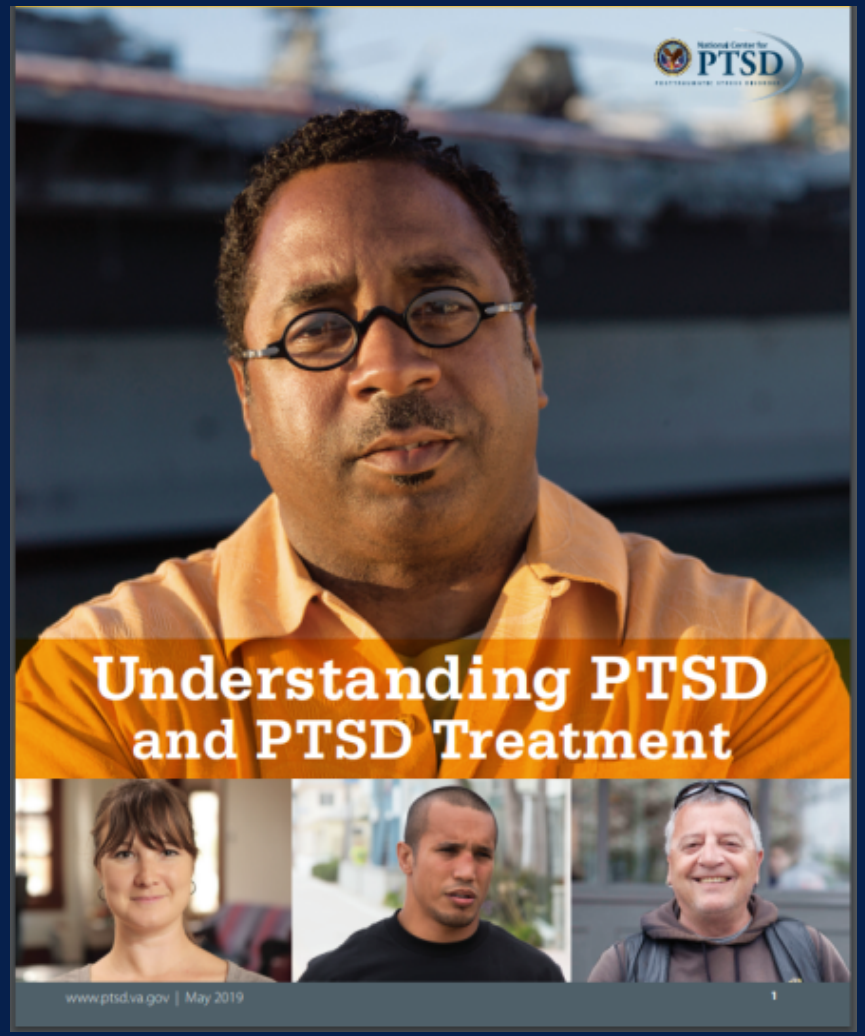
https://www.youtube.com/watch?v=C_3phB93rvI&t=8s

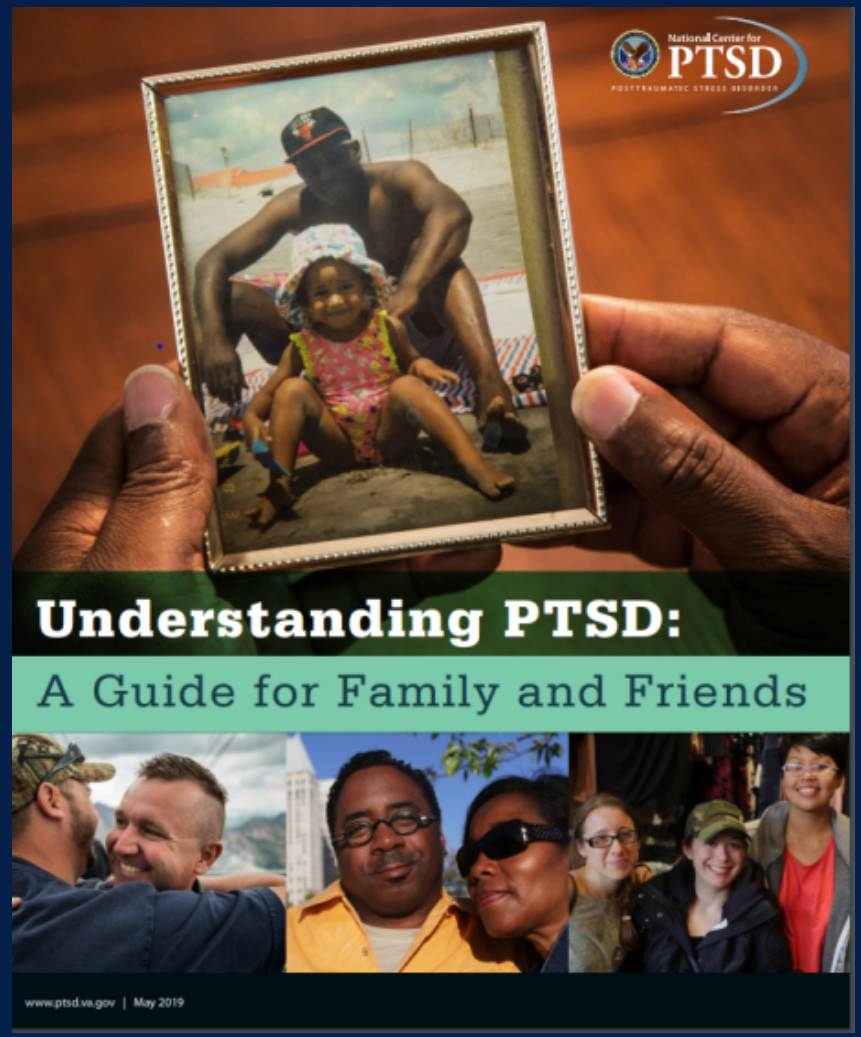
Chronic Pain Cycle



Motion is lotion!

PTSD Patient Education

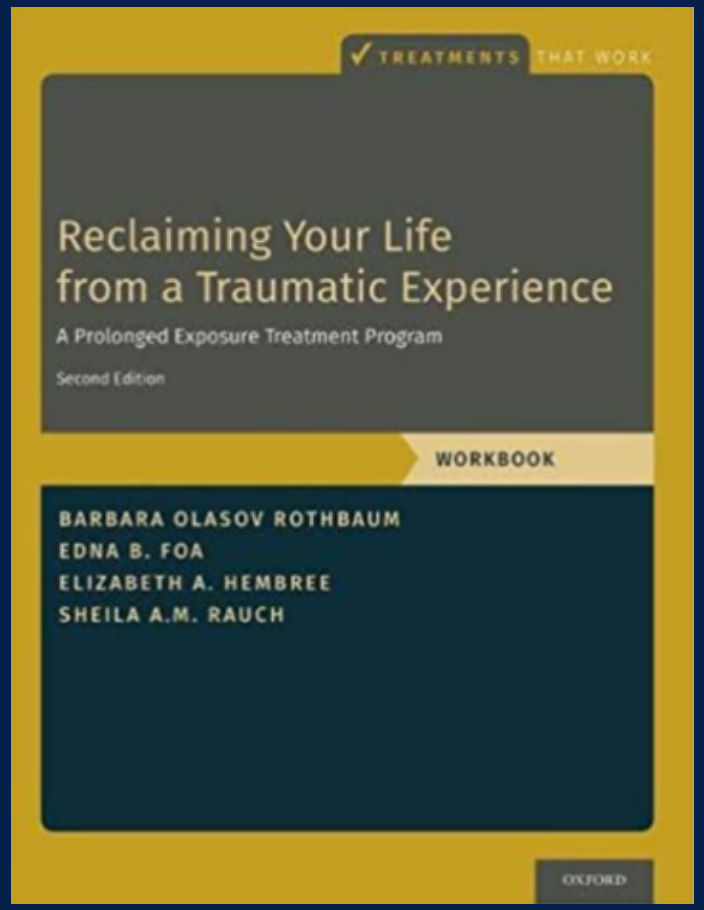


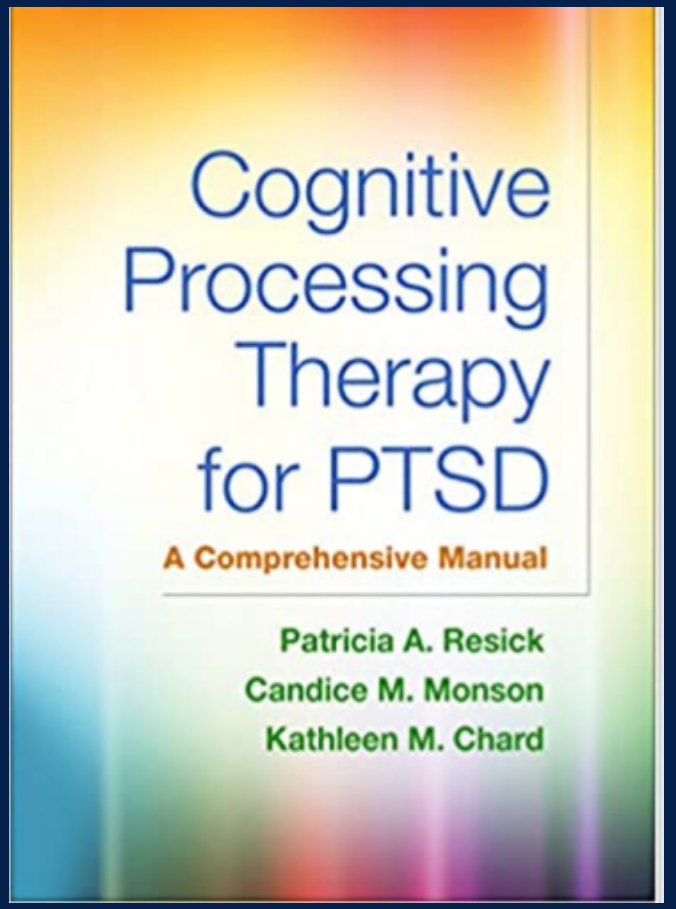


https://www.ptsd.va.gov/publications/print/understandingptsd_booklet.pdf

https://www.ptsd.va.gov/publications/print/understandingptsd_family_booklet.pdf

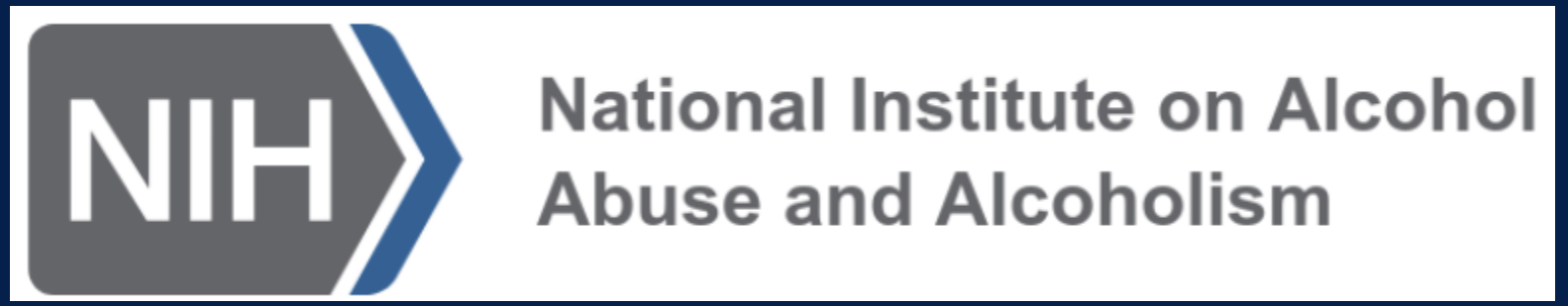
Evidence-based Psychotherapy for PTSD





Amazon.com

Addiction Education



Where to Refer Patients

Psychology Today

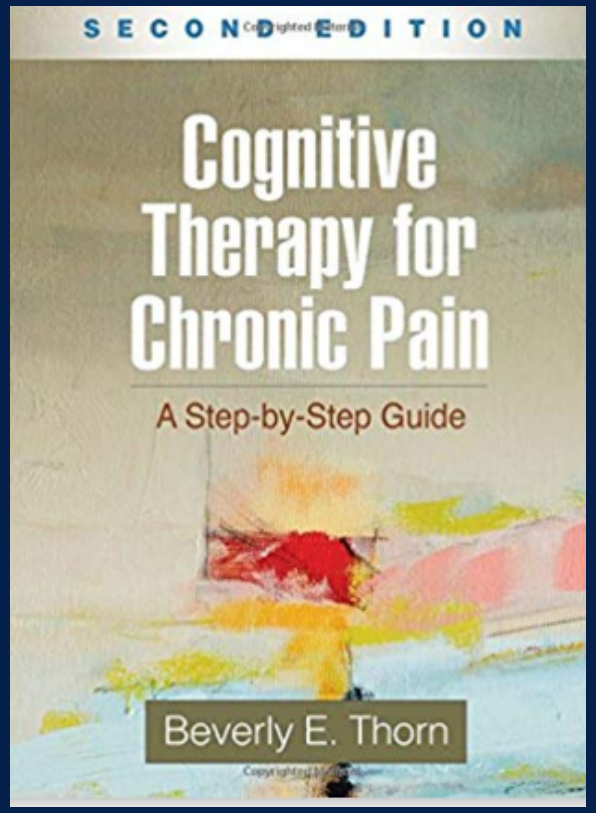
U.S. Department of Veterans Affairs
National Center for PTSD

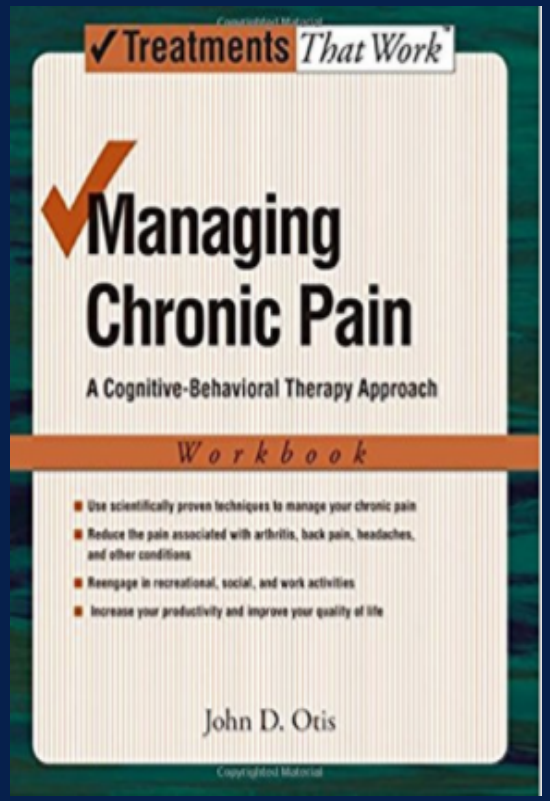
SAMHSA
Substance Abuse and Mental Health Services Administration
Behavioral Health Treatment Services Locator

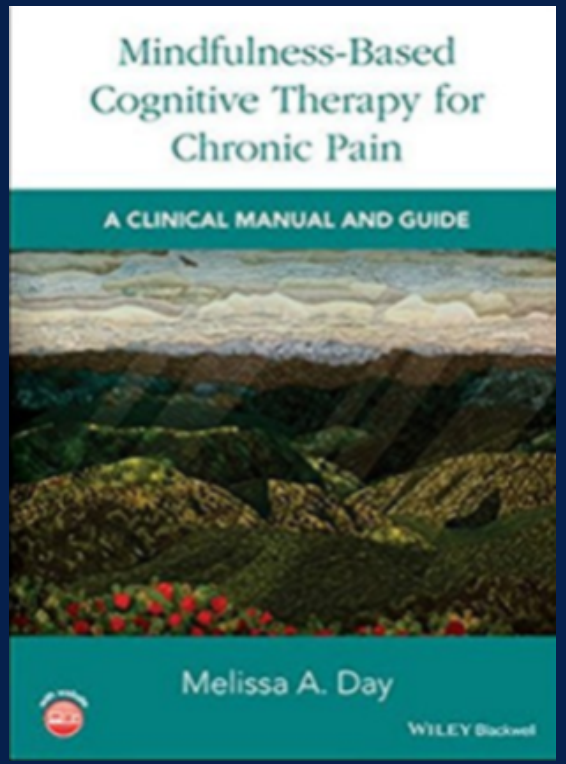
PSYCHOLOGIST LOCATOR
An official product of the American Psychological Association

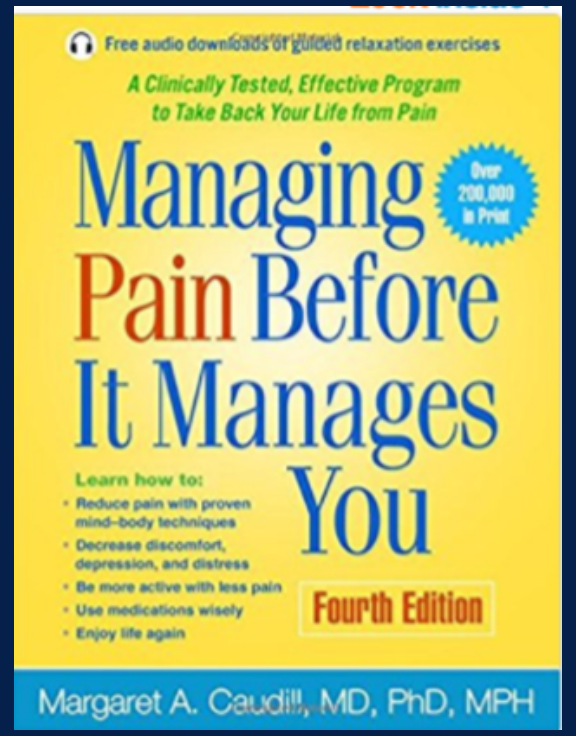
Washington State Psychological Association
Find a Psychologist

Evidence-based Psychotherapy for Chronic Pain









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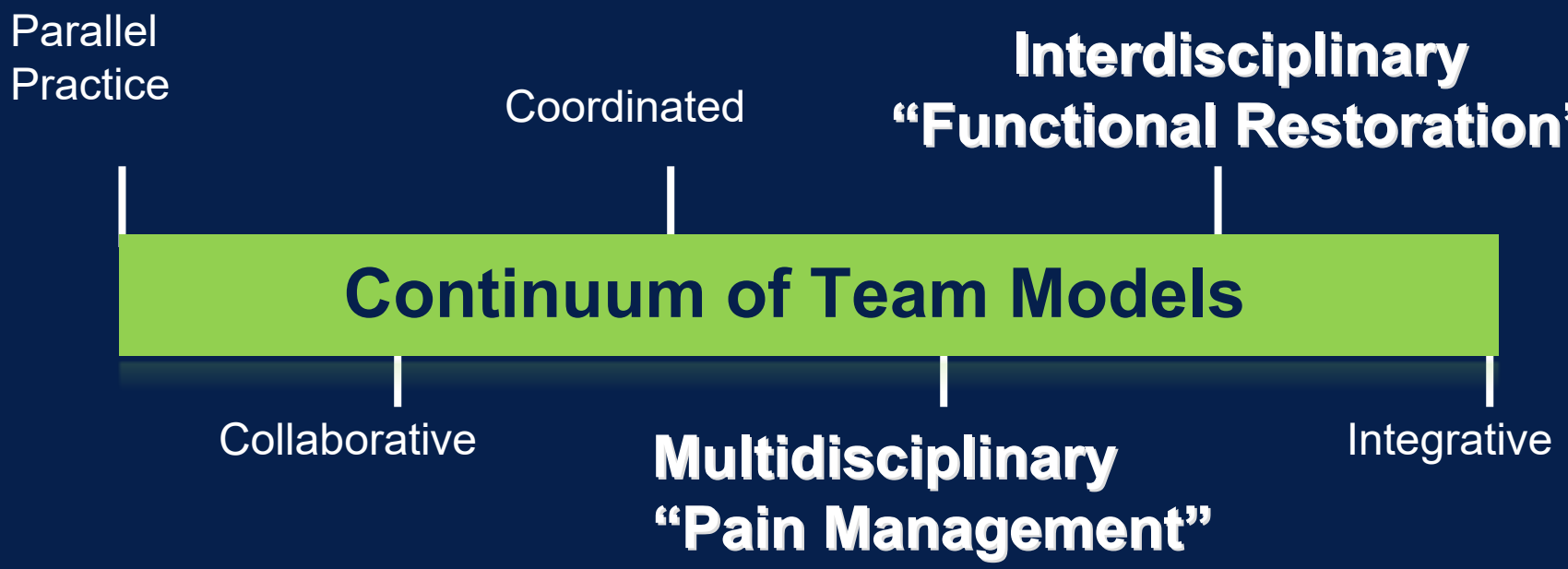
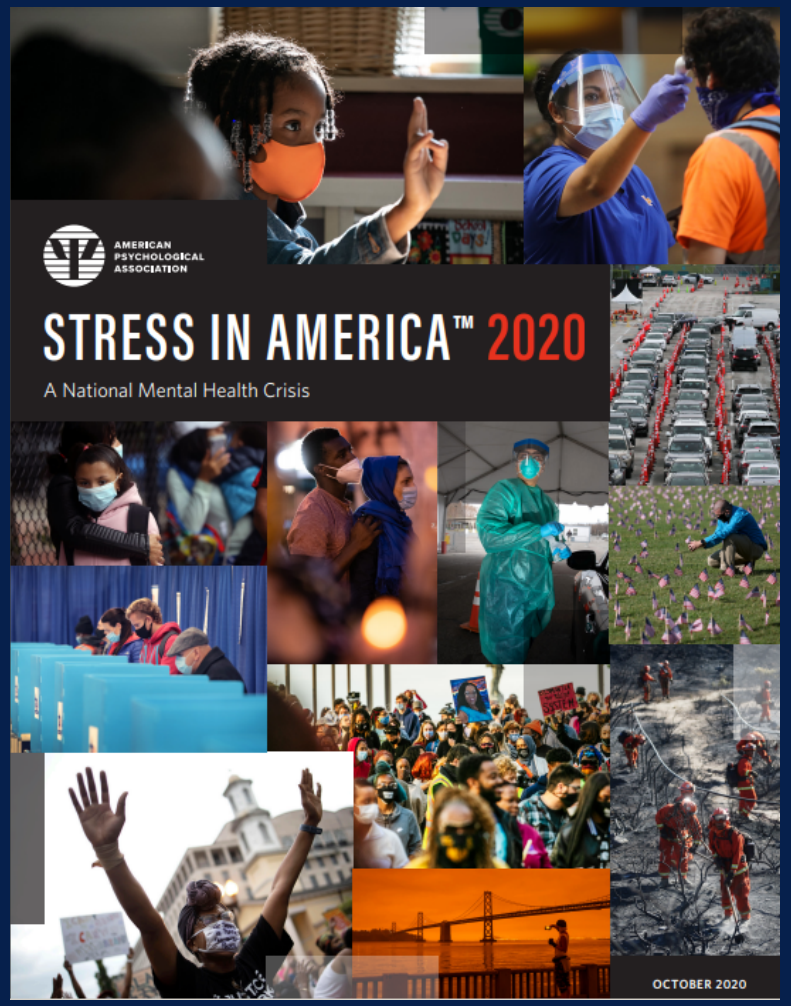
Treatment Model



(Boon H, et al., 12)

Learning Objective 4

Self Care- Why Now?

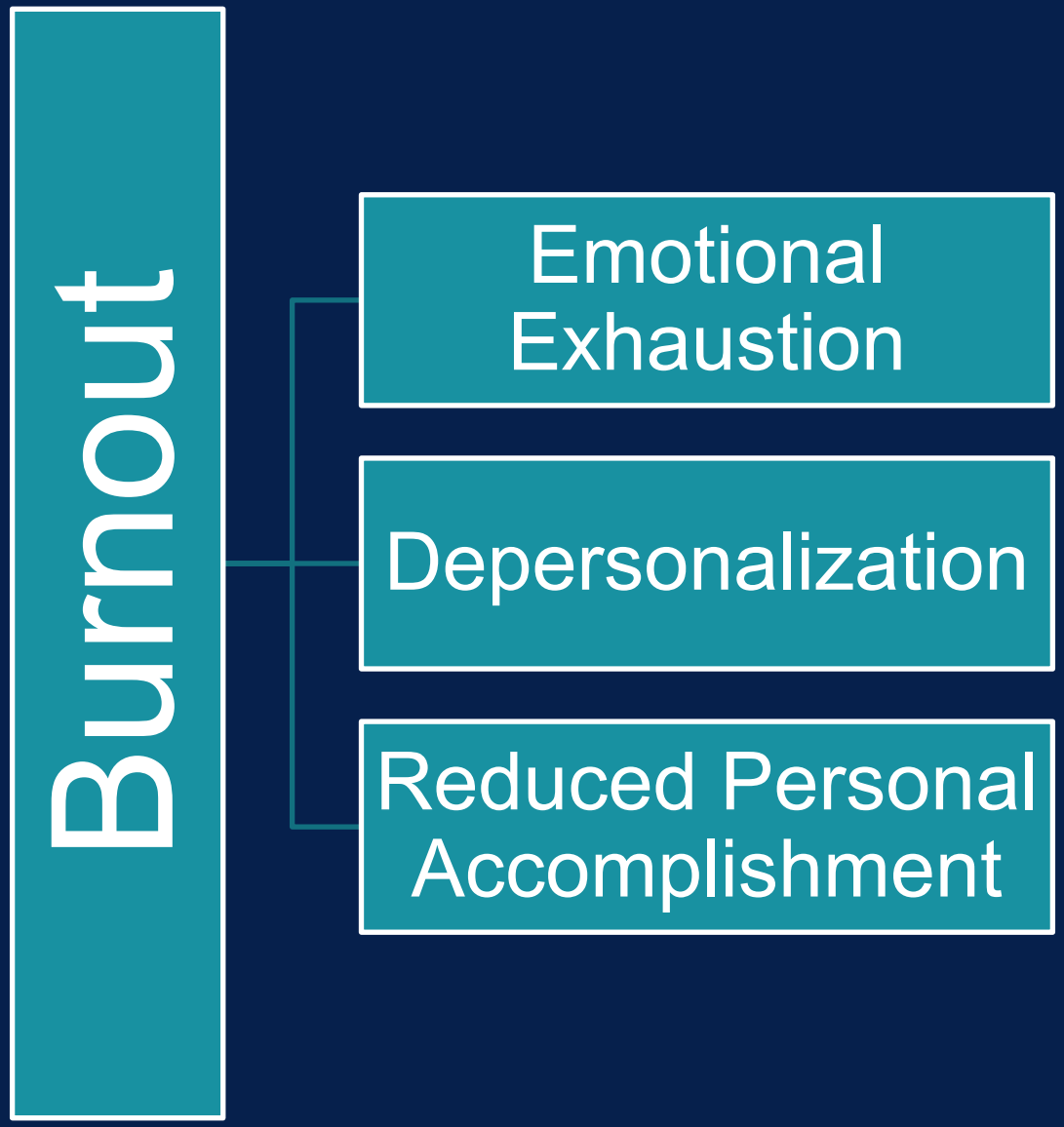


https://www.nytimes.com/2021/01/06/well/live/why-self-care-isnt-selfish.html?searchResultPosition=1
https://www.nytimes.com/2020/10/07/health/laurie-santos-covid-happiness.html?searchResultPosition=2
https://www.apa.org/news/press/releases/stress/2020/report-october

Compassion Fatigue

- Vicarious traumatization or secondary traumatization.
- The emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events. Compassion Fatigue can occur due to exposure on one case or can be due to a cumulative level of trauma.

(Figley, 13)



(Maslach et al., 14)

Figure 2. Promising interventions for clinician burnout

https://www.ahrq.gov/prevention/clinician/ahrq-works/burnout/index.html

Professional Quality of Life Scale

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

See handout. Available at https://proqol.org/uploads/ProQOL_5_English_Self-Score.pdf

Maslach Burnout Inventory

1.	**I feel emotionally drained by my work.**
2.	I feel used up at the end of the workday.
3.	I feel fatigue when I get up in the morning and have to face another day on the job.
4.	I can easily understand how my patients feel about things.
5.	I feel I treat some patients as if they were impersonal objects.

(West et al., 15)

Pocket Cards

CARING FOR YOURSELF IN THE FACE OF DIFFICULT WORK

Our work can be overwhelming. Our challenge is to maintain our resilience so that we can keep doing the work with care, energy, and compassion.

10 things to do each day

1. Get enough sleep.
2. Get enough to eat.
3. Vary the work that you do.
4. Do some light exercise.
5. Do something pleasurable.
6. Focus on what you did well.
7. Learn from your mistakes.
8. Share a private joke.
9. Pray, meditate or relax.
10. Support a colleague.

FOCUSING YOUR EMPATHY

Your empathy for others helps you do your job. It is important to take good care of your feelings and thoughts by monitoring how you use them. The most resilient workers are those that know how to turn their feelings to work mode when they go on duty, but off-work mode when they go off duty. This is not denial; it is a coping strategy. It is a way they get maximum protection while working (feelings switched to work mode) and maximum support while resting (feelings switched off-work mode).

How to become better at switching between Work and Off-Work Modes

1. Make this a conscious process. Talk to yourself as you switch.
2. Use images that make you feel safe and protected (work-mode) or connected and cared for (non-work mode) to help you switch.
3. Develop rituals that help you switch as you start and stop work.
4. Breathe slowly and deeply to calm yourself when starting a tough job.

See handout. Available at https://proqol.org/Helper_Pocket_Card.html

Resources

- Meditation and gentle yoga
  - UCSD Center for Mindfulness https://medschool.ucsd.edu/som/fmph/research/mindfulness/programs/mindfulness-programs/MBSR-programs/Pages/audio.aspx
  - App: UCLA mindfulness (English and Spanish recordings)
  - App: Insight Timer app
- Mindfulness courses and free drop-in session
  - https://ccfwb.uw.edu/events-classes/
- Lecture on mindfulness: Dr. Ron Siegel
  - https://www.youtube.com/watch?v=aPIG_w40qOE&t=603s

“We have not been directly exposed to the trauma scene, but we hear the story told with such intensity, or we hear similar stories so often, or we have the gift and curse of extreme empathy and we suffer. We feel the feelings of our clients. We experience their fears. We dream their dreams. Eventually, we lose a certain spark of optimism, humor and hope. We tire. We aren’t sick, but we aren’t ourselves.”

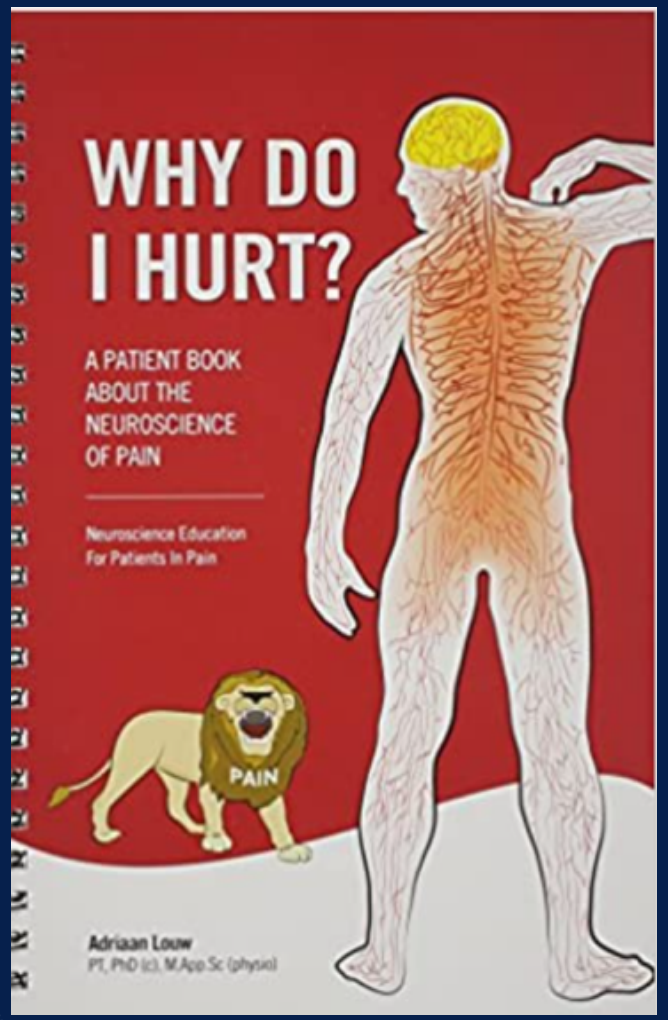
(Figley, 13)

Summary

1. Know when to refer your patients to counseling. Be familiar with symptoms and signs.
2. Learn to use Motivational Interviewing to work with your patients with chronic pain, PTSD, and/or addiction.
3. Become familiar with resources for patient education and know where to refer your patients.
4. Identify evidence-based tools for self-care to address compassion fatigue and burnout.

Additional Resources

Pain Neuroscience Education



See Amazon for products-
Adrian Louw, PT, Ph.D.

Pain Neuroscience Education

See Amazon for book by Lorimer Moseley, Ph.D. and colleagues

"Why Things Hurt" by Lorimer Moseley, Ph.D.

https://www.youtube.com/watch?v=gwd-wLdIHjs

References

1. Asmundson GJ, Bonin MF, Frombach IK, Norton GR. Evidence of a disposition toward fearfulness and vulnerability to posttraumatic stress in dysfunctional pain patients. *Behav Res Ther.* 2000;38: 801-812.

2. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch of Gen Psychiat*. 2005;62(6): 617-627.

3. Scaer RC. The body bears the burden: Trauma, dissociation, and disease. 2001. New York: Haworth Medical Press.

4. Bosco MA, Gallinati JL, Clark ME. Conceptualizing and Treating Comorbid Chronic Pain and PTSD. *Pain Res Treat*. 2013;2013:174728.

5. Turk DC. The role of psychological factors in chronic pain. *Acta Anaesthesiol Scand.* 1999 Oct;43(9):885-8.

6. Day M. Mindfulness-Based Cognitive Therapy for Chronic Pain: A Clinical Manual and Guide. 2017. ISBN: 978-1-119-25761-5.

7. Ishak NA, Zahari Z, Justine M. Kinesiophobia, Pain, Muscle Functions, and Functional Performances among Older Persons with Low Back Pain. *Pain Res Treat*. 2017;2017:3489617.

8. Hudes K. The Tampa Scale of Kinesiophobia and neck pain, disability and range of motion: a narrative review of the literature. *J Can Chiropr Assoc*. 2011;55(3):222-232.

References

9. Rollnick S, Butler CC, Kinnersley P, Gregory J, Mash B. Motivational interviewing. *BMJ.* 2010 Apr 27;340:c1900.
10. Fillingim RB. Individual differences in pain: understanding the mosaic that makes pain personal. *Pain*. 2017;158 Suppl 1(Suppl 1):S11-S18.
11. Mansour AR, Farmer MA, Baliki MN, Apkarian AV. Chronic pain: the role of learning and brain plasticity. *Restor Neurol Neurosci*. 2014;32(1):129-139.
12. Boon HS, Mior SA, Barnsley J, Ashbury FD, Haig R. The difference between integration and collaboration in patient care: results from key informant interviews working in multiprofessional health care teams. *J Manipulative Physiol Ther.* 2009 Nov-Dec;32(9):715-22.
13. Figley CR. Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (p. 3–28). 1995. The Sidran Press.
14. Maslach C, Schaufeli WB, Leiter, MP. Job Burnout. *Ann Rev of Psych.* 2001;52(1):397-422.
15. West CP, Dyrbye LN, Satele DV, Sloan JA, Shanafelt TD. Concurrent validity of single-item measures of emotional exhaustion and depersonalization in burnout assessment. *J Gen Intern Med*. 2012 Nov;27(11):1445-1152.