The Coleman Palliative Medicine Training Program

# CONFLICT RESOLUTION IN THE SETTING OF PAIN AND TRAUMA

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# Learning objectives

- Understand how the principles of conflict resolution can help conserve therapeutic relationships with patients.
- Understand how providers experience of vicarious trauma and response to conflict can threaten our abilities to be effective providers.
- Understand the importance of shared decision making in trauma informed care.

# Conflict Definition

Verb:

1. to come into collision or disagreement; be contradictory, at variance, or in opposition; clash.
2. To fight or contend; to do battle

Noun:

1. A fight, battle, or struggle especially a prolonged struggle; strife.
2. Controversy, quarrel: conflict between parties.
3. Discord of action, feeling, or effect; antagonism or opposition, as of interests or principles.
4. A striking together, a collision.
5. Incompatibility or interference, as of one idea, desire, event, or activity with another.

-Dictionary.com

# Conflict resolution

- The use of nonviolent resistance measures by conflicted parties in an attempt to promote effective resolution (Mayer, 2010).
- Methods and processes involved in facilitating peaceful ending of conflicts
- Involves attempts to communicate information about their conflicting motives

Dimensions

- **Cognitive resolution:** How participants understand and view the conflict.
- **Emotional resolution:** How participants feel about a conflict.
- **Behavioral resolution:** How the participants act.

Mayer, B. S. (2010). The dynamics of conflict resolution: A practitioner's guide. John Wiley & Sons.

# Theories and Models

**Dual Concern Model** for conflict is based on two underlying dimensions:

1. Concern for self (assertiveness) & concern for others (empathy)
2. Group members balance their concern for satisfying personal needs (pro-self) and the needs and interests of others (pro-social)

Rhoades, J. A., & Carnevale, P. J. (1999). The Behavioral Context of Strategic Choice in Negotiation: A Test of the Dual Concern Model 1. *Journal of Applied Social Psychology*, *29*(9), 1777-1802.

# Conflict Styles: **Conflict Avoidance**

Conflict Avoidance Style (that would be me ☺)

- Joking, changing the topic or even denying that a problem exists.
- The individual withdraws from dealing with the other.
- Wait and see approach may allow time for the problem to simmer down.
- Alternatively the problem may be allowed to spin out of control.

# Conflict Style: **Yielding Conflict Style**

- Accommodating or suppression conflict styles
- Display high levels of concern for others (prosocial)  and low levels of concern for oneself
- Great concern for maintaining stability and positive social relationships
- Tend to harmonize into others demands out of respect for the social relationship

# Conflict Style: **Competitive**

- “Fighters” maximize individual assertiveness (self-concern) and minimizes empathy (concern for others)
- Prize dominance over others
- See conflict as “win or lose”
- Compel others to accept their opinions by using power tactics: arguments, barbs, accusations
- Foster intimidation

# Conflict Style: **Conciliative**

- Compromising, bargaining
- Intermediate levels of concern for self and others
- Have give-and-take interactions
- They believe that their agreeableness will encourage others to meet them in the middle, thereby promoting conflict resolution.
- Similarities with yielding and cooperative styles

# Conflict Style: **Cooperation**

- Have active concern for both pro-self and pro-social behavior
- Deploy problem-solving conflict styles
- They collaborate with others in an effort to find an amicable solution.
- Both highly assertive and highly empathetic
- Because they see conflict as a creative opportunity, collaborators invest time and resources into achieving a “win-win” solution.

# Cultural contexts

- In the Western world conflict resolution usually involves the promotion of communication among disputants, problem solving and the development of agreements that meet underlying needs (“win-wins”)

# Cultural contexts

- In other cultural contexts while achieving a “win-win” solution is important,  direct communication  between disputants that explicitly names the issues can be considered impolite thereby worsening  the conflict
- Having a difficult conversation with the involvement of religious leader or member of a community based organization may foster better understanding when participants come from different backgrounds

# Being Present

- Conflict will often elicit flight-or-fight responses
- Be intentional about performing mindfulness activities to be an active, open, curious listener
- Involve an interdisciplinary team

Gerhart, J. I., Varela, V. S., & Burns, J. W. (2017). Brief Training on Patient Anger Increases Oncology Providers' Self-Efficacy in Communicating With Angry Patients. Journal of pain and symptom management, 54(3), 355-360.

Pene, C. T. H., & Kissane, D. (2019). Communication in cancer: its impact on the experience of cancer care: communicating with the angry patient and the patient in denial. *Current opinion in supportive and palliative care*, *13*(1), 46-52.

# Conflict Management

- The long-term management of intractable conflicts.
- Resolution involves achieving solutions which achieve the approval of both parties.
- Families and patients will have to live and die with the implications of the decisions that they make for far longer than the health care team

# Counseling

- Nondirective counseling or “listening with understanding”
- Allow the other person to express their feelings can help dissipate frustrations and allow an individual to proceed to problem solving.
- Listening without direction avoids the clinician diagnosing and interpreting emotional responses
- Chaplains and social workers are often better at this then medical providers.

# Step One: Clarify and Focus “Problem Ownership”

- Negative emotion such as anger and discomfort can hinder understanding of what is wrong in situations where confrontation is occurring.
- Getting some distance from negative emotions helps
- **Problem ownership:** deciding who should take ownership of the behavior or conflict in the issue. The owner  takes primary responsibility for solving the issue
- **It is important to ask questions that help us understand the root causes of the conflict.** Involve an interdisciplinary team.

# Step 2: Active listening

- Continually ask non-judgmental open-ended questions to test your understanding
- Let the other participant tell their story
- Paraphrase their story and confirm that your understanding is correct
- Don’t rush this
- Don’t jump in too soon

# Assertive I-messaging

- Comment about how behaviors are influencing the process to allow the other participant to reflect back on their thought processes and behaviors

“ I am hearing that you think……..

“ I am concerned that because more than one person is talking at the same time that people’s thoughts and opinions  are not being heard”

# Step 4: Negotiation

- When conflict persists over time
- Demands time and energy
- However ultimately it may sap less energy if people continue to cope with a conflict(s) over time

# Defining Trauma

- Definitions vary across time and disciplines
- A psychological, emotional response to a life threatening or body threatening event that is distressing or disturbing
  - Acute (Type 1)
  - Complex (Type 2)
- Rapid threats to essential resources
- Direct and indirect exposures

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.

Hobfoll, S. (2014). Resource caravans and resource caravan passageways: a new paradigm for trauma responding. *Intervention*, *12*(S1), 21-32.

Van der Kolk, B. A. (2017). Developmental trauma disorder: toward a rational diagnosis for children with complex trauma histories. *Psychiatric annals*, *35*(5), 401-408.

# Consequences of Stress and Trauma

- Exposure to early childhood adversity is linked to physical and psychological morbidities later in life.
- PTSD symptoms are associated with immune dysregulation
- Rates of PTSD tend to be elevated in samples of cancer patients.


Abbey, G., Thompson, S. B., Hickish, T., & Heathcote, D. (2015). A meta-analysis of prevalence rates and moderating factors for cancer-related post-traumatic stress disorder. *Psycho-Oncology*, *24*(4), 371-381.

Anda, R. F., Porter, L. E., & Brown, D. W. (2020). Inside the adverse childhood experience score: Strengths, limitations, and misapplications. American Journal of Preventive Medicine.

Hobfoll, S. E., Gerhart, J. I., Zalta, A. K., Wells, K., Maciejewski, J., & Fung, H. (2015). Posttraumatic stress symptoms predict impaired neutrophil recovery in stem cell transplant recipients. Psycho-Oncology, 24(11), 1529-1535.

# Manifestations of Trauma

- Galatzer-Levy & Bryant (2013): Each patient is unique: Over 600,000 ways to meet criteria for PTSD.
- Can include many psychological and physical symptoms

-Intrusive thoughts, memory loss, confusion

-Avoiding places or people who may be triggering

-Decreased participation in activities

-Severe fear, emotional blunting, depression, guilt, anxiety/ panic attacks

-easily startled, sexual dysfunction, hypervigilance

Galatzer-Levy, I. R., & Bryant, R. A. (2013). 636,120 ways to have posttraumatic stress disorder. *Perspectives on Psychological Science*, *8*(6), 651-662.

# Trauma informed care

**Use the 4 Rs:**
Realization of trauma's potential impacts
Recognition of symptoms and outcomes
Response based on integration of trauma knowledge
Resist Re-traumatization

**Three important elements**
Safety
Connections
Regulating emotions

SAMHSA-HRSA Center for Integrated Health Solutions. Trauma. https://www.integration.samhsa.gov/clinical-practice/trauma-informed

# Trauma, Pain and Medical Providers

- If we are consistent, reliable and trusting providers in their lives we help challenge their assumptions that others can not be trusted or relied upon.
- Conversations about tapering medication doses may trigger people with histories of trauma and to be interpreted as shaming or representing rejection
- When stopping an opioid medication do not frame it as an effort to reject someone from your practice. Maintaining the connection is highly valuable to the patient.
- The therapeutic relationship with a pain management provider may be one of the few safe spaces they have or have had in their lives.

# Emotional Regulation

- Active listening and validation of personal experience
- Mindful Attention
  - Present-Centered
  - Nonjudgmental
  - Intentional
- Labeling Emotions
- Reflective Statements

- Stress Reduction Techniques
- Dialectical Behavior Therapy

Barlow, M. R., Turow, R. E. G., & Gerhart, J. (2017). Trauma appraisals, emotion regulation difficulties, and self-compassion predict posttraumatic stress symptoms following childhood abuse. *Child abuse & neglect*, *65*, 37-47.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of psychopathology and behavioral assessment*, *26*(1), 41-54.

Rizvi, S., Steffel, L., & Carson-Wong, A. (2013). An Overview of Dialectical Behavior Therapy for Professional Psychologists. *Professional Psychology: Research and Practice*, *44*(2), 73-80.

# Best Practices for Trauma Informed Care

- Safety promotion
- Transparency
- Trustworthiness
- Peer Support
- Collaboration
- Empowerment
- Choice (Shared Decision Making)
- Reflective of the Cultural, Historical and Gender context

-SAMHSA 2014

# Challenge Common Concerns about Trauma Screening

- Worries about re-traumatization when screening for trauma or abuse
  - Discomfort is not the same as trauma.
- Concern that trauma survivors are not emotionally stable enough to discuss trauma
  - Most patients are okay. Some find benefit in disclosing.
- What do I do with the results if I don't have a mental health professional on my team?
  - e.g. the pre-adolescent sexual abuse question on the Opioid Risk Tool
- Not asking may make the patient feel safe.

# PTSD Screening Tools

- Screening tools are ideal for medical professionals
  - After screening, if clinically indicated, refer to mental health professional for further assessment

- PCL-5 (based upon DSM-5 PTSD criteria)
  - Screens for need for further assessment
  - Cut-offs depend upon patient population
  - Sensitivity = .88 ; Specificity = .69
    - Suggested cut-off: 31 – 33
  - Time to administer: 5-10 minutes
  - https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
  - Previous version based upon DSM-IV PTSD criteria:
    - PCL-Civilian, PCL-Military, PCL-Specific
    - Cut-offs not comparable to PCL-5


- Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. Journal of Traumatic Stress, 28, 489-498. doi:10.1002/jts.22059

- Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2015). Psychometric properties of the PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (PCL-5) in Veterans. Psychological Assessment, 28, 1379-1391. doi:10.1037/pas0000254

# Traumatic Event Screening

- Life Events Checklist for DSM-5 (LEC-5)
  - Aids in identifying exposure to Criterion A event
  - Provides qualitative information
    - No formal scoring or cut-offs

- https://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

- Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). The Life Events Checklist for DSM-5 (LEC-5). Instrument available from the National Center for PTSD at www.ptsd.va.gov

# Assessment of PTSD

- Clinician Administered PTSD Scale for DSM-5 (CAPS-5: Weathers et al., 2018)
  - Gold-standard
    - 30-item interview form
  - Administration time: 45 – 60 minutes
- Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5: Brown & Barlow; 2016)
  - Administration time: 120 – 240 minutes
- Structured Clinical Interview for DSM-5 (SCID-5: First et al., 2016)
  - Broad-band measure of psychopathology
  - Administration time: 30 – 120 minutes
  - Includes modules for anxiety disorders and trauma-related disorders
- **CAPS-5, ADIS-5, SCID-5 all require administration by trained mental health professional


- Brown, T. A., & Barlow, D. H. (2014). Anxiety and related disorders interview schedule for DSM-5 (ADIS-5L): Client interview schedule.
- First, M. B., Williams, J. B. W., Karg, R.S., & Spitzer, R.L. (2016). Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV). Arlington, VA: American Psychiatric Association.
- Weathers, F. W., Bovin, M. J., Lee, D. J., Sloan, D. M., Schnurr, P. P., Kaloupek, D. G., . . . & Marx, B. P. (2018). The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5): Development and initial psychometric evaluation in military Veterans. Psychological Assessment, 30, 383-395. doi:10.1037/pas0000486

# Patients may become upset

- Commonly used screening tools used in pain management settings can be upsetting for patients

  E.g. depression, PTSD, opioid risk screening

- When administering the Opioid Risk Tool you should have access to a mental health professional

# Opioid Risk Tool

| | | Female | Male |
|---|---|---|---|
| **Family history of substance abuse** | | | |
| | Alcohol | ☑1 | ☐3 |
| | Illegal drugs | ☐2 | ☐3 |
| | Prescription drugs | ☐4 | ☐4 |
| **Personal history of substance abuse** | | | |
| | Alcohol | ☑3 | ☐3 |
| | Illegal drugs | ☐4 | ☐4 |
| | Prescription drugs | ☐5 | ☐5 |
| **Age between 16-45 years** | | ☑1 | ☐1 |
| **History of preadolescent sexual abuse** | | ☐3 | ☐0 |
| **Psychological disease** | | | |
| | ADHD, OCD, bipolar, schizophrenia | ☐2 | ☐2 |
| | Depression | ☐1 | ☐1 |

**SCORING**

**0-3 Low Risk**

**4-7 Moderate Risk**

**>8 High Risk**

Webster, L. R., & Webster, R. M. (2005). Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain medicine, 6(6), 432-442.

# Consent orientated care

**Say to your patient**

You can stop ….. at any time.

You can speak up at any time.

Is it okay if I …..

Give your patient an out to not tell you about trauma

**Before you enter a patient's room knock**

**When you are leaving a patient's room ask if they prefer the door open or closed.**

# Barriers to Trauma Informed Care

- Vicarious trauma: in a study of patients attending a mindfulness training program 33% of participating palliative medicine clinicians screened at or above threshold for PTSD (O'Mahony et al., 2016)
- Time
- Lack of available mental health providers

O'Mahony, S., Gerhart, J. I., Grosse, J., Abrams, I., & Levy, M. M. (2016). Posttraumatic stress symptoms in palliative care professionals seeking mindfulness training: prevalence and vulnerability. Palliative medicine, 30(2), 189-192.

# Sleep and Chronic pain

- Post-traumatic stress disorder symptoms, sleep disturbance, pain intensity, and pain interference are all positively correlated
- Even after controlling for metastatic disease, race, and cancer type, sleep disturbance mediated the relationships between PTSD symptoms and pain intensity

Lillis, T. A., Gerhart, J., Bouchard, L. C., Cvengros, J., O'Mahony, S., Kopkash, K., ... & Burns, J. (2018). Sleep disturbance mediates the association of post-traumatic stress disorder symptoms and pain in patients with cancer. *American Journal of Hospice and Palliative Medicine*®, *35*(5), 788-793.

# What do medical providers bring to clinical interactions with patients that can elicit conflict

- If we sense anger from patients it may elicit a flight or fight response: we become angry or anxious or withdraw.
- Patients may interpret our words and opinions as judgmental, unfair.
- It threatens our ideal for ourselves when we are perceived as less than perfect by our patients.
- This can incite distress for the provider and interfere in our ability to communicate effectively and to actively engage in the care of our patients

# Applying Acceptance and Commitment to practice

- Does not require formal certification
  - “There is no ACT certification process. ACBS, as a community, has decided to forego this, as it could create a hierarchical and closed process which would be antithetical to our values. Rather, we aim to foster an open, self-critical, mutually-supportive community “ (Association of Contextual Behavioral Science(ACBS, 2018)
- ACT is designed to be useful to everyone, making it a framework that is flexible to each profession and adaptable to different populations of patients
  - Especially useful to bedside nurses given their contact with the patient and focus on education and improving patient outcomes
- Psychological care is currently underrepresented in palliative care, which comes at an emotional and monetary cost to patients and their families
- Palliative care patients have ever-changing life circumstances which require them to adapt to the contexts of their prognosis and continue to live values- guided lives
- Reduction in pain interreference and increased pain acceptance allows patients to experience greater autonomy and quality of life with reduced faculties

https://contextualscience.org/act

# Have systems to promote team cohesion when caring for patients that may be prone to conflict with providers

- Team meetings to devise a plan of care that is proactive and not reactive to conflict.
- Consider having a continuity provider.
- Screen for cognitive understanding (high levels of anxiety or depression may make it difficult for patients to process new information.
- Do teach back with the patient.
- Involve an interdisciplinary team that includes social workers.

# Conclusion

- Be mindful of what we bring to difficult conversations that may escalate conflict
- We can better manage the impact of vicarious trauma if use acceptance based approaches and  having a regular mindfulness practice
- Utilize shared decision making and the principles of trauma informed care


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