

Collaborative Communication in Trauma Informed Care: Motivational Interviewing

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Disclosure Statement

- Dr Pignataro provides continuing education courses for healthcare professionals through Professional Therapy Seminars and the Integrative Pain Science Institute
- No endorsement of products or services is intended or implied during this presentation



Session Objectives

- Describe the widespread impact of trauma on patients, families, and healthcare providers.
- Recognize diverse signs and symptoms of trauma.
- Apply universal trauma precautions to reduce the risk of re-traumatization
- Implement basic motivational interviewing techniques to improve interpersonal communication among people who may experience protective responses due to trauma exposure.

Widespread Prevalence of Trauma

- Approximately 70% of adults worldwide have experienced at least one traumatic event within their lifetime (World Mental Health Survey, 2016)
 - 30% reported four or more traumatic events
- Within the US, 90% of adults reported at least one traumatic exposure (Kilpatrick, et al, 2013)
 - 30% reported six or more traumatic events
- Why are accurate epidemiological data hard to obtain?

Examples of Trauma

- Experiencing or observing physical, sexual, and/or emotional abuse
- Intimate partner/domestic violence
- Childhood neglect
- Having a family member with a mental health or substance misuse disorder
- Experiencing or witnessing violence (within the community, military exposure)
- Poverty
- Systemic discrimination
- Natural disasters
- Refugee trauma
- Acts of terrorism
- Natural disasters
- Medical trauma

Medical Trauma

(International Society for Traumatic Stress Studies)

- Set of psychological and physiological responses to
 - Pain
 - Injury
 - Serious illness
 - Medical procedures
 - Frightening treatment experiences

- See course resources for ISTSS Clinician Fact Sheet:

<https://istss.org/wp-content/uploads/2024/08/Medical-Trauma-Clinician-Fact-Sheet-2-v2.pdf>

Distress Associated with Medical Events

- Nature of the illness or injury, nature of related treatment
 - Sudden, life-threatening
- Loss of sense of control associated with the diagnosis and/or treatment
- Unexpected interventions
- Conditions of the treatment environment – e.g. – noise, sleep disruptions, frequent checks
- Perceived and/or actual mistreatment by medical providers
- Gaslighting/medical mistrust

Acute Signs and Symptoms Associated with Trauma Exposure

- Fatigue
- Confusion
- Numbness
- Sadness
- Dissociation
- Nervousness
- Blunted affect

Persistent and/or Delayed Signs & Symptoms in Trauma Survivors

- Unrelieved emotional and/or mental distress
- Disruptive, intrusive memories despite a safe environment
- Sleep issues/nightmares
- Avoidance of situations, sensations or activities that are reminders of traumatic exposure
- Dissociation

Signs of Dissociation

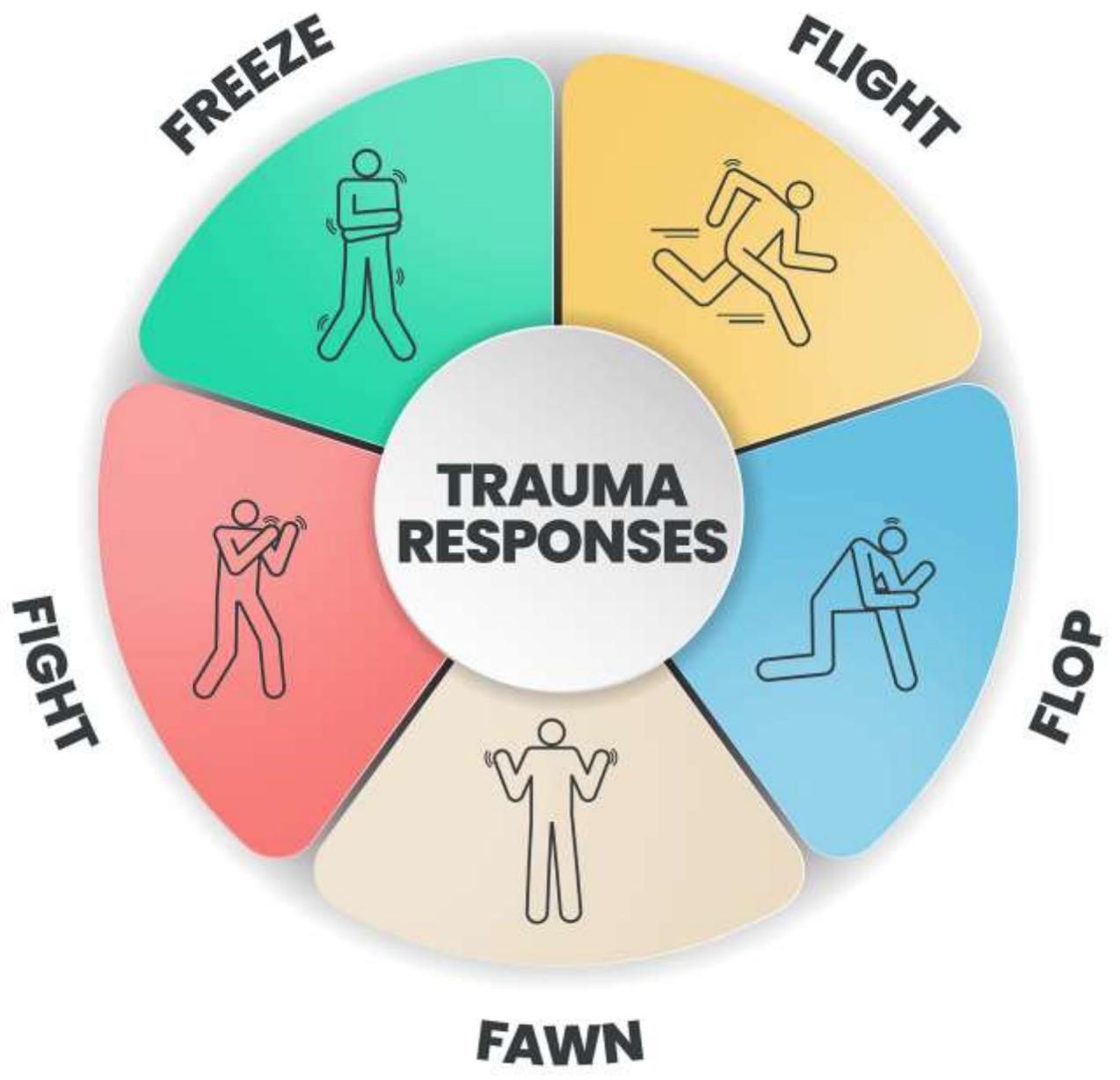
- Fixed and/or distant visual “glaze”
- Absence of appropriate emotional response
- Delayed and/or absent verbal responses
- Incongruent verbal or physical responses

Physiological and Psychological Consequences of Trauma Exposure

- Anxiety
- Depression
- Substance misuse
- Suicide
- Self-injury
- Increased likelihood of PTSD

Physiological and Psychological Consequences of Trauma Exposure

- Increased risks and incidence
 - autoimmune disease
 - chronic pain
 - Chronic systemic inflammation linked with metabolic disease, DM2, CVD
 - Autonomic dysregulation
 - Disability
 - Premature mortality
 - 20 year difference in life expectancy low vs high exposure to adverse childhood events (Afari et al, 2017)



Potential Effects of Trauma Exposure on Interpersonal Communication

People who experience trauma may display **protective responses** to reduce feelings of vulnerability (Levensen, 2020):

- Wary
- Guarded
- Angry
- Pessimistic
- May seem unmotivated or resistant

Some people who experience trauma may display **fawning or people pleasing behaviors** (Levensen, 2020):

- Passivity
- Dependence
- Deferential
- Fearful
- May seem needy

Potential Triggers within the Clinical Environment

- What is a trigger?
 - Stimuli that induce memories and/or reactions associated with the trauma
 - Vary by individual
 - May be conscious or subconscious
 - Patient may be unaware of a trigger
 - Different than flashbacks (re-experiencing trauma as though it were currently happening)

Possible Triggers within the Clinical Environment

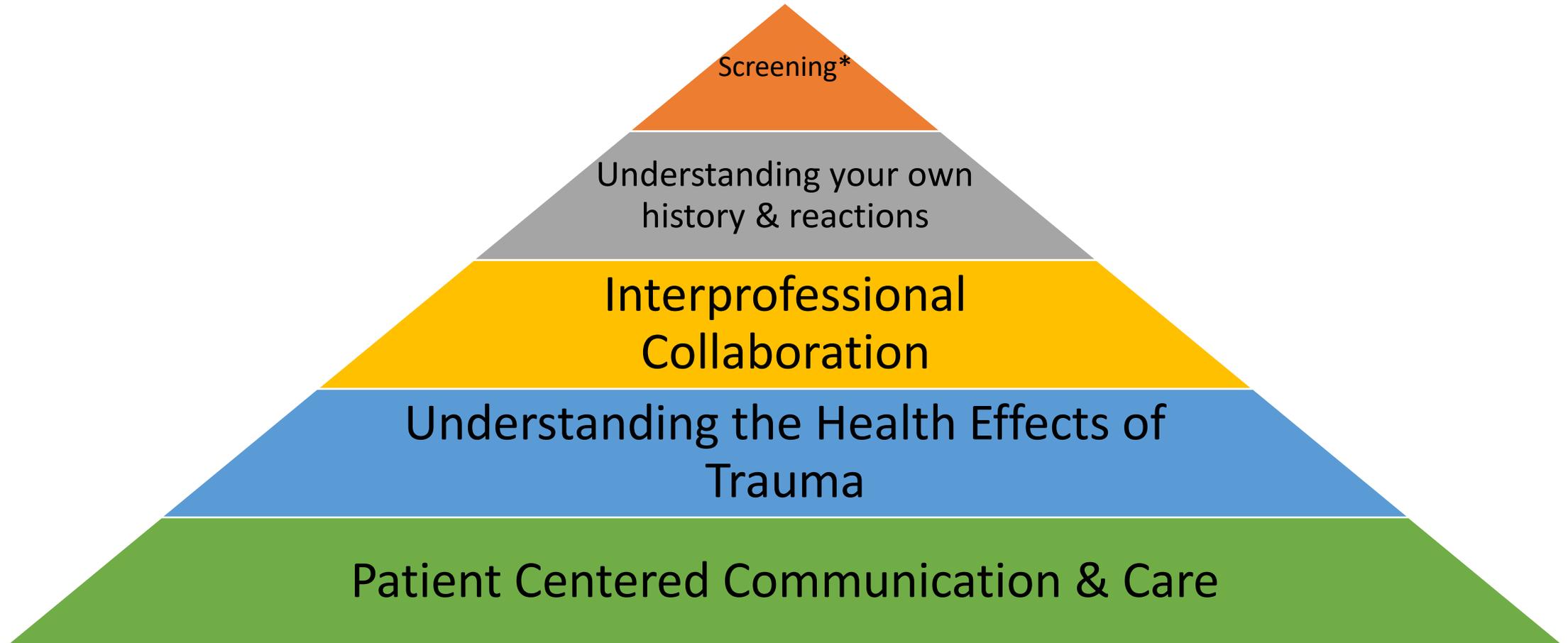
- Tightening of the BP cuff while taking vitals
- Asking the patient to disrobe to allow access to treatment site
- Having the pt lay prone or supine while the clinician is standing next to the treatment table
- Physical contact for palpation and/or manual therapy, tactile cuing
- Cardiorespiratory arousal during therapeutic activity/exercise

Triggers within the Clinical Environment

- Patient vulnerability, power differential
- Loss of personal privacy
- Fear of criticism or judgment by the healthcare professional
- **Collaborative communication techniques can modulate threats and triggers**

The Trauma Informed Care Pyramid

(Raja, et al, 2015)



Trauma-Informed Care

- Universal trauma precautions (SAMHSA, 2015; Raja et al., 2015)
 - Enables recognition of diverse signs and symptoms of trauma in patients/clients, colleagues & other stakeholders
 - Avoids re-traumatization – allows us to defer seeking specific information about trauma exposure until rapport & therapeutic alliance has been established
- Cumulative effects of trauma exposure – many adults with multiple trauma experiences can develop complex trauma responses (Briere, Agee & Dietrich, 2016)

Screening for Trauma

- APTA HOD P06-20-40-10:
- “It is within the professional scope of physical therapy practice to screen for and address behavioral and mental health conditions in patients, clients, and populations.”
- Screening for signs and symptoms vs details about traumatic exposures

Screening for Trauma: Patient History

- Questions about signs and symptoms
 - Sleep impairments
 - Difficulty concentrating
 - Agitation
 - Self-isolation
 - Mood changes
 - Anxiety
 - Fear
 - Depression



Screening for Trauma: Physical Exam

- Attention towards symptoms of sympathetic nervous system arousal in trauma survivors
 - Sensitivity to sound and tactile stimuli
 - Exaggerated startle reactions
 - Muscle tension
 - Elevated HR, RR, and blood pressure



Standardized Assessment Tools

- **PTSD screens**

- Primary Care PTSD Screen for DSM-5 – self-report
- PTSD Checklist for DSM-5 – self-report
- PTSD Scale (CAPS-5) – clinician administered

- **ACEs screen**

- Adverse Childhood Experiences (ACEs) Questionnaire
 - 10 items re: childhood trauma exposure
 - 5 personal items: physical abuse, verbal abuse, sexual abuse, physical neglect, emotional neglect
 - 5 related to family structure and dynamics: parent is an alcoholic, parent is a victim of domestic violence, family member in prison, family member with mental illness, disappearance of a parent due to divorce, death or abandonment

6 core principles of trauma-informed care



1. Safety

When people feel safe, healing can begin.



4. Collaboration

Working together with honesty and respect paves the way to healing and recovery.

2. Trustworthiness

Transparency and clarity helps build a sense of trust.



5. Empowerment

Believing in someone's resilience helps them believe in themselves.



3. Choice

Giving people agency lets them decide what feels right.



6. Cultural, historical & gender considerations

Equitable care is achieved by responding to people's unique experiences.

Additional Assets

- Private areas for sensitive communication, examination and interventions
- Shared decision making
 - Promotes increased sense of control
 - Deciding how the patient will communicate distress and how the PT should respond, e.g. – managing triggers or flashbacks
- People first language and culturally responsive communication to reduce stigma
- PTs' knack for individualized patient rapport
 - Routinely asking patients what makes them most comfortable
 - Allowing time for questions – reduces fear and anxiety

Responsive, Collaborative Communication Strategies



What is motivational interviewing (MI)?

- Intentional style of collaborative communication
- Originally designed to explore & address challenging behaviors – e.g. – addiction/substance misuse (Miller & Rollnick, 2023)
- Facilitates personalized treatment planning and plans of care (Buckner, 2024)

MI and TIC

- MI helps promote resilience
 - Can be used to encourage self-regulation, decrease distress
- MI can assist in navigating protective responses
 - People with trauma histories may feel vulnerable
 - Can seem unmotivated or resistant
- MI can encourage active engagement
 - People with trauma histories may display fawning or people pleasing behaviors
 - Can seem passive or dependent, “needy”

Benefits of MI

- Enables insight into contextual factors that influence behavior:
 - Emotional factors
 - Psychological factors
 - Cognitive factors
 - Social factors – relationships & social support
 - Environment
- Opportunity to explore patient perceptions and expectations
- Provides strategies for tailored, individualized conversations about productive coping
 - Empowerment
 - Coaching to develop greater self-insight and self-regulation

Empowerment

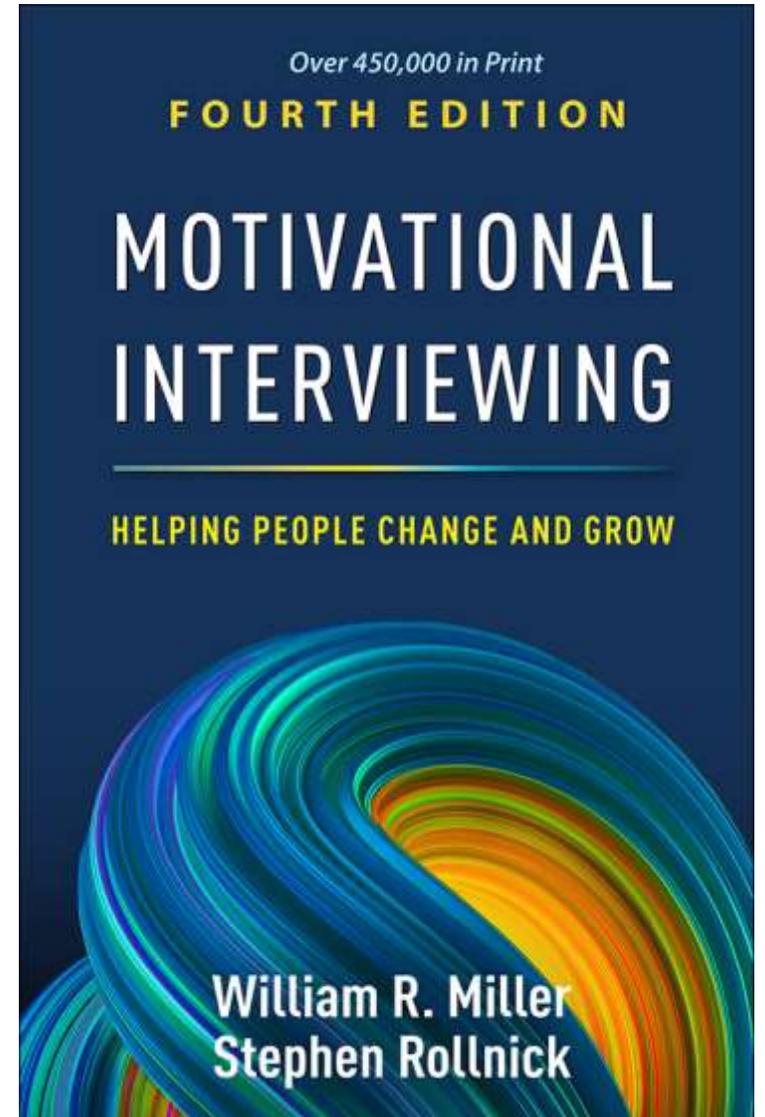
- Increases intrinsic motivation – treatment concordance
- Promotes autonomy, reduces feelings of vulnerability
- Associated with higher satisfaction levels
 - With patient care
 - With our work environment
 - General life satisfaction

Additional Benefits of MI

- Allows us to provide feedback to one another in a non-judgmental manner
- Works best when change is challenging and/or we are resistant to change
 - Low awareness of problem
 - Low desire to pursue a solution
 - Benefits of change are unclear
 - Confidence in changing is low
 - Low perceived importance – things “as is” aren’t so bad
 - Accommodation is a trauma response

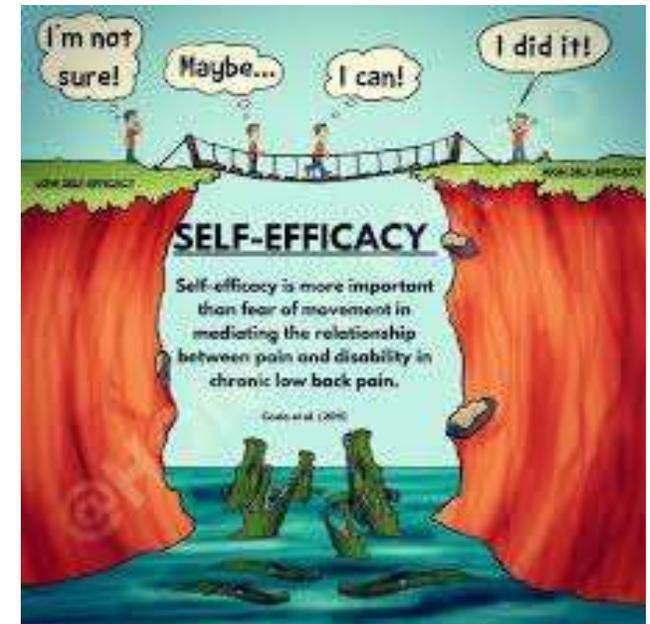
MI: Underlying Tenets

- We have the inherent capacity for behavior change consistent with our personal goals and values
 - Personal growth
- Intentional conversations can promote awareness of our
 - Need and ability to change (building self-efficacy)
 - Best strategies for achieving our goals
 - Readiness to change
 - Perceived barriers and facilitators



MI: Foundational Principles

- Unconditional positive regard
 - Conveying empathy and mutual respect
 - Non-judgmental approach
 - Promoting interpersonal engagement
- Developing discrepancy
 - Discussing differences between behavior and goals/intention
- Rolling with resistance
 - A safe space for authentic dialogue
 - Validation of fears and concerns
- Supporting self-efficacy



Empathy vs Sympathy

- Similar terms
 - May have similar intentions – conveying support and understanding
- Differ in how it might make the person experiencing loss or difficulties feel
- Empathy – shared experience or shared understanding
 - Common ground
 - Can strengthen trust and rapport
- Sympathy – pity based on someone else's loss or challenges
 - Can feel hierarchical – “better you than me”
 - Can contribute to feelings of isolation

SYMPATHY



EMPATHY



Conveying Empathy

- Exploring shared values
 - Agendas are based on topics that are the most important to the individual
 - Priorities set based on the person's own goals
- Shared learning
 - Reciprocal exchange of knowledge
 - Respect for the individual as the authority re: their own experiences and choice of coping strategies
- Supported by active listening and receptive body language

Developing Discrepancy

- Allowing space for the individual to recognize the conflict between their behaviors and their goals/intentions
- Avoids assumptions
 - Leaves room for patient to explore reasons for reactivity – increases self-awareness
- Promotes self-regulation
 - Bringing behavior into alignment with personal goals and desired outcomes

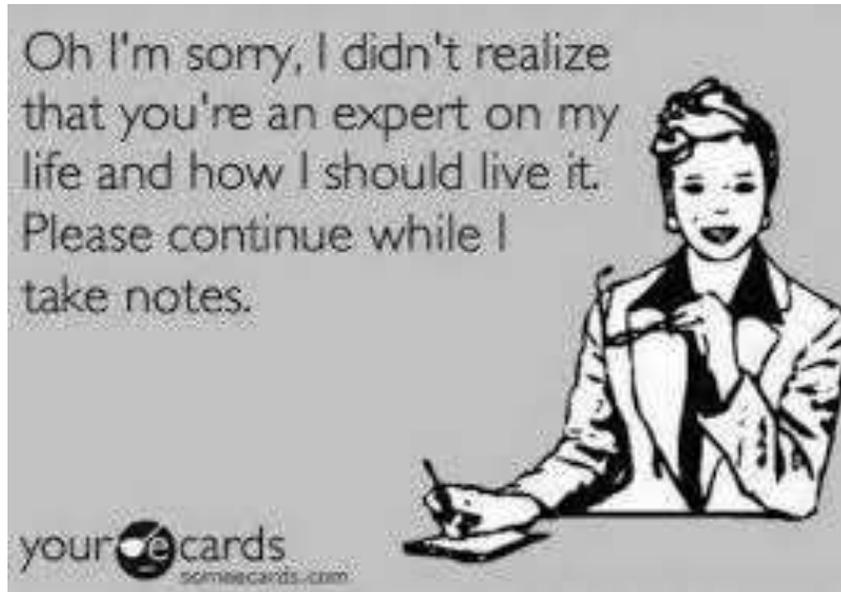
Rolling with Resistance (Levensen, 2020)

- Resistance can reflect the need for safety despite wanting change
 - Ambivalence towards change
- Rolling with resistance preserves therapeutic alliance
 - Avoids an adversarial relationship and patient defensiveness
 - Emphasizes respect for autonomy
 - Supports self-efficacy
- Reframing resistance as a natural reaction may encourage greater likelihood of concordance and continued follow-up

Our “Righting Reflex”

- Wanting to help can sometimes make us a little too pushy!
 - Continuing to emphasize the need for change can provoke continued resistance
- Instead, emphasize the person’s right to self-determination
 - Their choice
- As a clinician, reflective practice is essential
 - Have the confidence to be wrong!
 - Allow the patient to redirect or correct you

The “Righting Reflex”



- Self-determination is powerful
 - We are more likely to be persuaded by what we hear ourselves say than by what someone tells us to do
- “Talking myself into something”

How People Express Resistance

- Actively
 - Counterargument
 - Interrupting in a defensive fashion
- Passively
 - Withdrawing from conversation
 - Exhibiting inattention
 - Being non-responsive to questions
 - Side-tracking



Techniques for Rolling with Resistance

- Openly acknowledging that disagreement is possible and not necessarily a bad thing
 - Resistance to change is human nature
 - Discussion can create realistic strategies
- Affirm the person's autonomy
 - "I didn't mean to tell you what to do. Only you can decide what is best for you."
- Use an assets-based approach vs over-attention towards negative factors or circumstances
 - Reduces risk of re-traumatization
 - Provides hope that things can be different

Techniques for Rolling with Resistance

- Promote expression of fears and concerns
 - Empathy
- Allow the person to set the time and agenda for further discussion
 - “I am sorry if I seemed pushy. I am just concerned about you. Please let me know if there’s a better time that we can talk, or if there is something else you would rather discuss.”



I have made
a mistake

MI Process: The 5 A's

- **Assess** – situation, behaviors/response, readiness to discuss and change coping strategies
- **Advise** – use a personalized approach to indicate why you are concerned
- **Agree** – set realistic goals and expectations together with the individual
- **Assist** – collaborative planning for best ways to change the situation
- **Arrange** – follow-up support

MI and TIC: Informed Consent/Shared Power

(Levensen, 2020)

- Ask, don't tell
 - Avoid giving advice or recommendations without permission
- ***“Would you be willing to sit with me for five minutes to try and help me understand what is upsetting you?”***
- ***“What can we do to make you more comfortable?”***
- ***“How can I help understand and address what is making you so angry right now?”***
- ***“What is the best way for us to handle this?”***

MI and TIC: Shared Power

- **“Are there specific things that are worrying you right now? Will you tell me about them?”**
- **RULE**
 - Resist the righting reflex
 - Understand the person’s motives
 - Listen empathetically
 - Empower and encourage



MI Techniques: OARS

- Open ended questions
- Affirmations
- Reflective listening
- Summarization



Open-Ended Questions

- Invites the person's perspectives – ***“what do you think is best?”***
 - Empowerment
 - Shared decision making
 - Allows patient to do most of the talking
- Can be used in assessment
 - Readiness to change
 - Perceived barriers and facilitators
 - Goals and expectations
 - Social context
- Keeps conversation flowing as opposed to yes/no questions

Examples of Open-Ended Questions

- *How can I help with _____?*
- *How would you like things to be different?*
- *What is the best outcome you can imagine?*
- *How can we get there together? What is getting in the way of your goals?*

Examples of Open-Ended Questions in TIC

- Asking about resilience vs talking directly about the traumatic experience (Assets based)
- ***What types of strategies have worked well in the past to overcome challenges like this?***
- ***Which people close to you usually help support you?***
 - ***Who can you share your thoughts and feelings with?***
 - ***Who seems to appreciate your strengths?***

Using Open-Ended Questions to Support Self-Efficacy

- ***There are a lot of possible solutions, but you are the one who should decide what will work best for you. Of all the options we have talked about, which ones sounds like they would be the most helpful?***
- ***Would you like me to share some strategies that have worked for other people who were managing similar situations?***
- ***What are the next steps you think you should take?***

Affirmations

- Strengthen rapport, show that you are listening and genuinely interested
- Can be used to provide ongoing encouragement and support self-efficacy
 - Emphasize the person's strengths and accomplishments
- Highlights ability to change
 - Beliefs, values, productive behaviors

Examples of Affirmations in MI and TIC

(Levensen, 2020)

- ***Even though you are facing a lot of challenges, I can see that you are determined to find better ways of getting through this.***
- ***Thank you for your willingness to speak with me about this. I know it's a very difficult topic.***
- ***I really value your input.***
- ***I hear that you feel betrayed.***

Reflective Listening

- Can assist in diffusing conflict
 - ***I am hearing you explain how frustrating this is for you. I apologize if I didn't seem more understanding***
 - ***It sounds like you have had some very negative experiences with people trying to tell you what to do without considering things you have already tried and new ideas you might have about what could help***



Reflective Listening

- Can be used to check for accuracy
 - *If I understand correctly, you are concerned that you won't be able to find enough time for better self-care*
- Promotes self-awareness
 - *It sounds like you have a lot of personal responsibility right now, and that is contributing to your stress levels.*
- Can be used to guide people towards greater recognition of the problem and its relationship to their behavior
- Can be used to reframe resistance and **highlight change talk**
 - *What I am hearing is that even though we all have busy schedules, finding time to connect with your support system would help you build your confidence*

Phrases that Can Facilitate Reflection

- *It sounds like ...*
- *You seem to be thinking ...*
- *From your point of view ...*
- *What I am hearing is ...*
- *The thing that bothers you most is ...*
- *I would imagine that you ...*
- *So you're saying ...*



Summarizing

- Basically, a longer version of reflections
 - Draws together multiple statements from the conversation
- Enables us to selectively emphasize points of discussion
 - Recognition/acknowledgement about the need for change
 - Concerns or hesitancy in making a behavioral change (ambivalence)
 - Hope or optimism for making a change
 - Solutions to perceived barriers

Summarizing

- End with an invitation
 - *Is there anything else you would like to add?*
 - *Did I miss anything, or is there anything that I haven't understood correctly?*
- *What's the next step?*



Trauma Informed Self-Care

- Learning how to be sensitive and aware of potential effects of our own personal trauma
- Recognizing and responding to professional trauma – e.g. – changes in workload, responsibilities, billing restrictions, etc
- Trauma informed self-care reduces burnout, secondary traumatic stress, professional attrition

MI and TIC: Team Communication within the Clinical Environment

- Can be used to help one another recognize signs of professional burnout and vicarious trauma
 - Mindfulness
- Can be used to help one another prioritize good self-care
- Can promote collaboration
 - *“This is really overwhelming. How can I help you in this moment?”*

Case Scenarios



...thinking caps activated!

Creating a Safe Space

- Anna is a 22 year old newlywed referred to PT secondary to pelvic pain and dyspareunia. During the patient history, Anna is tearful and provides very limited responses. She shows signs of increased sympathetic activation including increased RR, heart rate, and flushing of the face.
- How would you use MI and TIC to help diffuse this situation?

Promoting Collaboration

- A patient switched from another PT to your schedule. Your first visit together is challenging. The patient is very critical of your colleague and expresses dissatisfaction with the plan of care, even though the interventions seem appropriate given her clinical presentation. The patient states that she hasn't experienced any benefits since starting PT more than a month ago and that she isn't sure she wants to return. She is "giving you one last chance."
- Challenges:
 - The original treating therapist is your supervisor and is a very experienced and accomplished clinician
 - The patient's medical record lists lack of treatment adherence (missed appointments, not performing home exercises) as a possible reason for lack of progress
- Using a trauma-based lens, what are some of the possible reasons for the patient's reactivity?
- How might MI assist in a productive resolution?

Encouraging Self-Care

- One of your colleagues is a highly experienced pelvic health specialist. They are returning to work after a 6 week leave of absence following a miscarriage. You notice that your colleague is quieter than usual and seems withdrawn. Later in the day, you enter the office and find her staring into space at her computer. She confides in you that she is concerned about a loss of interest in her work and a possible loss of empathy for post-partum patients.
- How would you use MI/TIC to help your colleague manage this situation?

Questions and Discussion



- Rose Pignataro
 - rpignataro@emoryhenry.edu
- Resources:
 - https://drive.google.com/drive/folders/1vdX-dbK8e3TzL-41KooL_Sr29oDT4MTH?usp=sharing

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