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ABSTRACT

As literature has shown, chronic pain patients present with a unique challenge to the medical field. The existing question is if the patient's pain is unmanageable because of the severity of the pain or if the patient lacks coping mechanisms. If there is a lack of coping mechanisms, then that raises a plethora of new questions for the medical teams caring for them. After IRB approval, the current study was conducted on a sample of three patients that were referred to the Hendrick Medical Center Pathways team for pain management. It sought to determine if there was any association between their suspected pain management issues and prior emotional trauma. Each individual was administered the Trauma History Questionnaire, which revealed that each patient had a very complex trauma history. The findings suggest the importance of an interdisciplinary approach that includes trauma informed protocols when caring for patients with chronic or unmanaged pain.

Chronic Pain and History of Trauma

A Thesis

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The Faculty of the School of Social Work

Abilene Christian University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Science in Social Work

By

Lauren K. Grizzard

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To my dad, the late Russell Grizzard, and my mom, Lori Grizzard, to Carson and Kresha, to Breklyn, to Aimee, to Grant, to The Lodge: Kendall, Staci, and TylerRose. This thesis is dedicated to all the many friends and family who told me I could. Most importantly, it is dedicated to the many people who pointed me back to Jesus along the way. I will never be able to thank you enough for that.

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TABLE OF CONTENTS

	LIST OF TABLES	iii
I.	INTRODUCTION	1
II.	LITERATURE REVIEW	4
	Child Abuse and Later Pathologies.....	4
	Trauma Association with Chronic Pain	7
	Specified Pain	9
	Education	11
III.	METHODOLOGY	13
	Participants.....	13
	Trauma History Questionnaire.....	13
	Pathways at Hendrick	14
IV.	RESULTS	16
	Table 1	16
	Table 2	17
	Table 3	17
	Table 4	18
V.	DISCUSSION.....	19
	Implications for Practice.....	19
	Implications for Research	21
	Limitations	23

REFERENCES	25
APPENDIX A: IRB Approval	30

LIST OF TABLES

1. Demographics	16
2. THQ: Crime Related Victims	17
3. THQ: General Disaster and Trauma Victims.....	17
4. THQ: Physical and Sexual Experiences	18

CHAPTER I

INTRODUCTION

Chronic pain patients present with a unique challenge in the medical field. Medical teams often wonder why some individuals can cope with their pain and why some cannot. When a patient has an acute medical issue, it is more common that the medical teams can identify and appropriately treat the presenting problem. However, when a patient who has persistent pain that lasts three months or more, it can be said the patient has chronic pain. When an individual has chronic pain, it affects their physical functioning and quality of life (Robertson, Smith, Ray, & Jones, 2009). Patients with chronic pain often seek treatment primarily from physicians. There is a dimension of spiritual or emotional pain that is not being considered due to physicians' training to treat patients' physical complaints (Burns, 2010).

Undiagnosed etiologies for their chronic pain may often result in an individual suffering from depression and anxiety. It is important to appreciate that even when a physician cannot fully identify the underlying medical cause that there is not a lack of pain or perceived pain in that patient (Jacobson & Hatchett, 2014). The "treat first" mentality of many medical professionals involved in a chronic or unmanaged pain case would suggest that medical teams should consider assisting the patient in developing coping mechanisms to live with their chronic or unmanaged pain. This would be especially important in those cases where there is no clear rationale (i.e., diagnosis) to justify treating the patient's complaints.

When considered from this perspective, the medical model of “treatment” would potentially benefit from a more holistic approach that initially focuses on coping. Langenhof and Komdeur (2018) suggested that coping is “the behavioral and physiological efforts to master a challenging situation” (p. 3). The sad truth is that there are increasing numbers of those who have pain that medical teams have chosen to provide pain medication rather than treat their medical complaints effectively. This is why chronic pain patients are some of the most difficult cases that a physician may face (Jamison, Link, & Marceau, 2009).

Patients with generalized complaints may have non-specific diagnoses, yet they continue to suffer. As the national number of those addicted to pain medications would suggest, patients are often on very high doses of medications for pain and or anxiety but report having little, if any, relief of their symptoms. The patient becomes increasingly difficult for the provider to treat when they become addicted to prescription medicines and/or other substances that they may use to substitute (Jacobson & Hatchett, 2014). Some become addicted to intravenous pain medicine and short- and/or long-acting opioids and still struggle with their chronic pain. What medical professionals have learned is that intravenous pain medicine and short- and/or long-acting opioids are no long-term fix for chronic pain. These individuals often get labeled as “drug seekers” within the medical system, and their pain continues to go untreated or treated incorrectly.

There is a significant difference between a “drug seeker” and a “relief seeker.” It is likely that many people who get a label of a drug seeker are in fact just searching for relief, even if they know the relief will not last. It is important for medical teams to be able to note the difference between those who have been treated with pain medications, in

the absence of a clear rationale for doing so, and those who are truly addicted and seeking relief from withdrawal symptoms. The ability to discern between these two significantly different patient needs can greatly impact the type of care given to a particular patient. There are patients who enter the medical system who are there to seek relief from their symptoms. On the other hand, there are patients that enter the medical system who may be asking for opiates because of the relief they provide. This does not necessarily mean they are drug seeking but instead the drug they are asking for may be the only relief they have ever experienced for their pain (Zelda Foster Conference, NY, 2019).

In simple terms, this information suggests that the question of what and when to treat a patient for chronic pain is one of the most complex issues found in clinical medicine as traditional approaches have not been effective. In fact, they have proven to be very destructive when it comes to pain management. The purpose of this study is to determine if there is an association between patients who struggle with chronic pain and have a history of trauma. It is hoped that the findings from this work will help guide the palliative care team at Hendrick Medical Center to better address this problem locally.

CHAPTER II

LITERATURE REVIEW

Child Abuse and Later Pathologies

It is no secret that child abuse falls under the broader category of trauma. The literature would lead one to question the idea that child abuse has recently fallen under the category of trauma. Early literature (prior to 1990) considered child abuse as a specific etiology for later problems. The most recent literature does not make that distinction, and maltreatment (i.e., abuse or neglect) has been identified as one of many forms of trauma that results in distressing cognitive symptoms (Szabo, Nelson, & Lantrip, 2020). Even when considered from a more traditional perspective, victims of child abuse, maltreatment, or neglect have a completely different worldview. Findings indicate that a part of their treatment should be to reteach realistic views of the world and oneself (Ferrajão & Elklit, 2020). What this explains is that it is likely that those who have lived through abuse in their childhood years have a distorted view of the world and even their own self. Not having a realistic worldview can stunt development and cause irrational thinking. In other words, its presence is associated with the overall issue of trauma related dysfunction.

Not all victims of child abuse will have cognitive impairments, although there is evidence that this is more likely to occur than not (John, Cisler & Sigel, 2017). In addition to generalized cognitive impairments and developmental delays, a history of child abuse can also lead to an individual being diagnosed with post-traumatic stress

disorder (PTSD). Adolescent females that present with a history of child abuse have shown a decreased ability to regulate their emotions and suffer from mental health difficulties (John et al., 2017).

One of the reasons it is pertinent that medical teams are screening for emotional regulation is that patients who have a history of child abuse are more likely to have suicidal ideation (Wong, Kuo, Sobloweski, Bhatia, & Ip, 2019). Not only are these patients more likely to attempt suicide, but if they fail, they are likely to attempt a second time. In short, there is a significant correlation between patients who have a history of child abuse and suicidal behavior. One study combined environmental stressors and physical child abuse to see if that resulted in increased depressive symptoms in adulthood (Kopeck & Sayre, 2005). The data ended up being significant in that children who grew up in a stressful environment and experienced physical abuse were more likely to have depressive symptoms and struggle overcoming adversity.

Not only can a history of child abuse affect one's cognitive thinking, but it can also take a toll on one's physical being. A crucial part of any child growing up is their developmental process. There are many aspects that go into helping a child grow mature. Studies show us that if a child has been abused or neglected that they will have developmental delays (Bengwason & Bancual, 2020). A childhood history of child abuse or neglect indicates that it is more likely they will have generalized development delays as well as specific delays depending on their demographic factors. There is research that shows that individuals who have a history of child abuse are more likely to develop an eating disorder (Rodgers et al., 2019). This is a result of a cognitive disconnect that

directly affects the individual's physical body. Within the eating disorder one may develop there is research that shows how one's mood directly affects appetite.

In addition to pathologies that affect the physical body, evidence supports that individuals, specifically men, who were abused as children have decreased sexual functioning (Kolacz et al., 2015). A human's nervous system is designed to send threat-reactive functions throughout one's body, which means that an individual's nervous system can train itself to put up defense mechanisms when the body is being threatened. Even as an adult, it can be challenging for the individual to retrain the nervous system. There are many ways that a history of abuse can affect a patient's well-being, including being more susceptible to infectious diseases (Dargan, Daigneault, Overtchikine, Jud, & Frappier, 2019). Specifically, the studies say that a patient with a history of child sexual abuse is 1.27 more times likely to be diagnosed with an infectious disease, which suggests there is a direct correlation between child sexual abuse and infectious disease diagnoses.

In addition to a history of child abuse affecting an individual's emotional and physical well-being, there is also significant research that shows how a history of child abuse is likely to have an impact on relationships of those people (Szepsenwol, Zamir, & Simpson, 2019). One study in particular looked at the correlation between early life trauma prior to the age of five and interpersonal conflict and violence and one's capacity to have a meaningful and romantic relationship in adulthood. There showed a significant correlation between these variables. Once again, also suggests importance of screening individuals for childhood trauma before they endure any medical care or counseling for

research shows that a history of childhood abuse or neglect could potentially play a significant role.

In conclusion, there is no doubt from these studies that child physical abuse, child sexual abuse, and child neglect play a significant part in the development of a child. This development includes cognitive functioning, physical functioning, and relationship development. Even though the historical references made no mention of trauma, the recent ones stress a more holistic approach for assessment and treatment that includes a much broader definition of trauma exposure and trauma-informed therapy and practice. As the THQ includes child physical abuse, child sexual abuse, and child neglect as part of the questionnaire, it will be defined as a traumatic experience. It has always been known that the abuse or neglect of a child would affect them in their later years, but until trauma-informed therapy began to trend in recent studies, researchers did not know just how much the trauma of childhood abuse would affect someone in their adulthood.

Trauma Association with Chronic Pain

Some research has suggested that significant trauma history would impact the way patients could manage their pain effectively. This study in particular focused not on whether or not the pain was real or what the pain was stemming from but instead on the patient's ability to cope and get their pain to a manageable level (Spertus, Burns, Glenn, Lofland, & Mccracken, 1999). The mystery remains as to why some patients find and develop efficient mechanisms to cope with their pain and why some do not or cannot. Recent scientific studies have been interpreted to prove that the impact of trauma has the power to reshape the body and brain (Kolk, 2015). Kolk acknowledges that a significant number of Americans will experience trauma in their life and the approach to treating

trauma should take new advances. As a recent piece of literature, Kolk groups many different instances under the broad umbrella of trauma. Studies show that there is a direct correlation between higher resilience scores and less intensity of pain (Newton-John, Mason, Hunter, 2014). It is important to note that the language in that study is “less intensity.” This implies the patient is still identified to have chronic pain, but it made it more manageable due to the fact they had developed a different level of resilience within their coping mechanisms. Chronic pain has been linked to abuse and other trauma which is commonly beyond the primary doctor’s scope of practice (Burns, 2010). In addition to the link between trauma and chronic pain there is also a link between a history of trauma and a history of depression (Tennen, Affleck, & Zautra, 2006). One study found that an individual with a history of depression would have decreased efficacy in coping with their chronic or unmanaged pain.

Research shows that childhood trauma exposure is significantly related to that child growing up and having chronic pain. Child abuse is broader than physical and sexual abuse. Childhood abuse includes but not limited to physical abuse, sexual abuse, verbal abuse, exposure to alcoholism, drug dependence, medication exposure, and major upheaval. Childhood trauma is but not limited to those things mentioned plus childhood illness, death of a family member or friend, and separation or divorce of parents. Medical teams need to begin to shift their focus to interdisciplinary treatment for the patient battling chronic pain and their families (Goldberg, Pachasoe, & Keith, 1999). Other studies show that multiple stressful or traumatic experiences in childhood increases the risk for that person to develop chronic back pain later on in adulthood (Kopec & Sayre, 2005).

Specified Pain

For a patient to have successful clinical care, the clinician must be intentional about thoughtfully looking at all dimensions of the patient's illness. A significant part of any clinician treating a patient's pain must include the clinician understanding the patient's pain. This could include asking the patient questions like, "What does your pain feel like right now?", "If you could assign a word to your pain, what would it be?", and "If your pain could talk to you, what would it say?". Research shows a significant correlation between trauma and the development of adult physical and mental conditions (Brady, 2017). Statistics show that 1 in every 500 African-American people are born with sickle cell disease or SCD (Works, Jones, Grady, & Andemariam, 2015). Although SCD is known for being an acute episode event, 44% of people with SCD will develop chronic pain. Minimal research has been done examining the association between a history of trauma and having SCD.

Research tells us that of the 70% of adults in the United States who have lived through a traumatic event at least one time in their lives, 20% develop PTSD. Traumatic experiences and pain in non-SCD patients have been established but not the influence of traumatic experiences and SCD-specified pain. In a study done to establish this influence, chronic pain was specified as a patient reporting to have pain more than half their days for over six months. A *traumatic experience* for the sake of this study was defined as witnessing or being threatened with an event that involves actual injury, a threat to the physical integrity of one's self or others, or possible death. One of the findings within this study is that the individuals who had chronic pain related to their SCD were more likely to be on daily opioids and there was a trend up in hospitalizations for acute pain. Thirty-

two patients within the study indicated a need for mental health counseling, the clear majority of them reported at least one traumatic exposure. The most key finding identified in this study is that traumatic exposure is a risk for the presence of chronic pain.

Research shows that women with chronic pelvic pain have a high PTSD percentage screening, and many of them have experienced a traumatic event in their life. Due to this research, it is highly important that medical teams screen for trauma exposure in women who present with chronic pelvic pain. Chronic pelvic pain is not just a temporary condition but one that must be of at least six months' duration, severe enough to require medical care or cause disability and occurring in locations such as the pelvis, anterior abdominal wall at or below the umbilicus, lower back, or buttocks (Meltzer et al., 2007). In the Meltzer et al. (2007) study, 713 women patients were used, and 34% reported having a history of sexual abuse, 28.9% reported physical abuse, and 46.8% reported having sexual or physical abuse or both. Almost one third (31.3%) screened positive for PTSD. This study showed that having a positive screen for PTSD was greatly related to that patient having a poor health status. As one would guess, more trauma exposure was directly linked to having a worse health status in all variables. This study also suggests that women patients with PTSD are more likely to rate their pain as being severe than those who do not have PTSD.

Recent articles suggest that the prevalence of chronic pain increases with a person's age. As of 2019 the prevalence of chronic pain in older adults is 42.5% in the United States (Ho, 2019). As could be expected, chronic pain greatly decreases older

individuals' quality of life, as most of the chronic pain they experience is recorded to be in their lower limbs.

One study explored the possible correlation between history of trauma and gastrointestinal disorders (Sherman, Morris, Bruehl, Westbrook, & Walker, 2015). The study found that patients who had a history of trauma reported greater severity within their gastrointestinal disorder than without a history of trauma. Patients with a history of trauma and a gastrointestinal disorder also reported more pain sites and a lower ability to function. Studies such as this one have the potential to assist medical teams in identifying a group of patients who may be at risk for an increase in pain compared to patients who have experienced no trauma or little trauma in their life.

Education

Once the results of the Trauma History Questionnaire are received and analyzed, it will be determined if the patient has had a history of trauma. As part of routine practice, the patient will receive education on non-medicinal coping mechanisms and be taught ways to become more flexible within their lives. Research on coping with pain has been evolving since 1980. There are many different perspectives and definitions for this, as it is different for each specialty, which could be hindering the development of this idea. There is literature to be found for individuals coping with cancer pain or arthritis, but it seems as if there is less literature for individuals who are lacking a diagnosis of cancer or arthritis. Knowing this information, it is crucial the practitioner understands the concept of coping with generalized chronic pain (Ho, 2019). As can be imagined, patients may be frustrated or confused when a clinician suggests non-medicinal coping mechanisms. Patients may become offended and may think the clinician thinks they do not have real

physical pain. It is crucial that the clinician communicates that they believe the patient's pain is real, not in their head. The language used should imply that the patient has physical pain and that there are ways one can train the brain to think that can directly impact the patient's mobility and comfort. This is not intended to throw in the patient's lap with a "good luck" mentality. It is meant for the clinician to come alongside the patient and help them develop coping mechanisms and maybe they will realize they had that mechanism all along (Turk & Gatchel 2002). In the hospital setting, it is important to note that the interdisciplinary teams may only have a few days with the patient. With many unknowns in this setting, it will be crucial that the researcher empowers and educates the patients so they feel like they can continue the interventions learned when they return to their place of residence.

The researcher should also recommend counseling specified with the phrase, "coping with chronic pain," as the Pathways Palliative Care team does not offer outpatient pain management at this time. When patients leave the hospital, they must make an outpatient appointment, which could take several days, weeks, or even months. In one study, it was found that 60%-70% of patients require counseling while they are waiting for an appointment with a primary care doctor. Of those, 40% of those patients are referred to a counselor, and only 10% of those patients follow through and proceed with counseling (Aitken & Curtis, 2004). It has been indicated that a patient who has chronic pain will have a better outcome if they received mental health counseling along with whatever various treatment they were on to treat their physical pain (Jacobson & Hatchett, 2014).

CHAPTER III
METHODOLOGY

Participants

The participants of this study were English-speaking adults that were inpatient patients at Hendrick Medical Center. These patients had to be referred to the Pathways Palliative Care team for pain management by their primary or consulting physician on the patient's medical team. Once the patients were identified, they were given a consent form and once they gave informed consent the Trauma History Questionnaire was administered.

Trauma History Questionnaire

As mentioned before, the tool used to define trauma for the sake of this study is called the Trauma History Questionnaire. This questionnaire is divided into three sections titled crime-related events, general disaster and trauma, and physical and sexual experiences. The whole questionnaire has 24 questions. The Trauma History Questionnaire is unique in that it uses neutral behavior language, and it was developed to be applicable for a wide variety of populations. The Trauma History Questionnaire can be used as a self-report instrument or as an interview. Oddly, there is no standard scoring method for this particular questionnaire, so the scoring can be modified to fit the particular project for which it is being used. The Trauma History Questionnaire is one instrument that gives a researcher or clinician initial information regarding specifically Criterion A1 stressors for PTSD (Hooper, Stockton, Krupnick, & Green, 2011).

Pathways at Hendrick

The team that will be receiving these referrals for these patients is called Pathways Supportive Care and Palliative Medicine. This team is in Hendrick Medical Center in Abilene, Texas. This team is consult-based and operates off a scatter model. There is not a floor or department in the hospital from which the Pathways team will not accept a referral. The team receives consults for a multitude of things, including pain management, goals of care, family dynamics, emotional support, and advanced care planning. This particular study will include only the patients that are referred to the Pathways team for pain management. When an existing provider on the patient's case identifies a need in a patient that the Pathways team could help, they send in the referral. The referral shows up on the census of the Pathways interdisciplinary team, which gives them access to the patient's chart and records. The Pathways team will only address the need that is identified by the provider who consulted them. The Pathways team sees chronic and/or terminally ill patients within Hendrick Medical Center. It is vital that the Pathways team can get the patient on a pain medicine regimen with which they can return home, not just provide a temporary solution or temporary relief. This task becomes difficult when there is a patient who suffers from chronic and/or uncontrolled pain because it is possible that the pain will be a part of the rest of their life. The case becomes increasingly difficult if the patient has poor coping skills, which can result from an experience of trauma. The tool used to help define trauma for the sake of this study is the Trauma History Questionnaire (THQ). The THQ is divided up into three separate categories. The categories are crime-related events, general disaster and trauma, and

physical and sexual experiences. There are 24 questions that make up these three categories.

CHAPTER IV

RESULTS

The profile of the patients who agreed to participate could best be described as middle-aged and female (see Table 1). They were all Caucasian and suffered from different diagnoses.

Table 1

Demographics (n=3)

Variable	
Age	
Mean	40 years
Range	28-49 years
Gender	
Male	<i>n</i> =1/33%
Female	<i>n</i> =2/66%
Ethnicity	
Caucasian	<i>n</i> =3/100%
Non-Caucasian	<i>n</i> =0/0%
Admitting Diagnosis	
Osteomyelitis of right toe	<i>n</i> =1
Left sided weakness	<i>n</i> =1
Alcoholic cirrhosis	<i>n</i> =1

The THQ responses were reported in Tables 2-4. The participants' history of crime-related experiences consisted of a majority who had been victims of some form of crime (see Table 2). The only type of crime to which they had not been exposed was having been burglarized while they were in the home.

Table 2

THQ: Crime-Related Victims

Variable	<i>n</i> =Yes/ <i>n</i> =No
Victim of assault	2/1
Robbery victim	2/1
Burglary victim/not there	2/1
Burglary victim/there	0/3

The participants' history of general disaster and trauma consisted of a majority who had experienced one of the following thirteen scenarios. All of the participants have dealt with unexpected trauma and in some cases, violent death of a family member or loved one. The only questions that were not shared by all three participants were exposure to dangerous chemicals and military service.

Table 3

THQ: General Disaster and Trauma Victim

Variable	<i>n</i> =Yes/ <i>n</i> =No
Serious Accident	1/2
Natural disaster	2/1
Man-made disaster	2/1
Exposure to dangerous chemicals	0/3
Serious injury	2/1
Fear of being injured or killed	2/1
Seen someone injured or killed	1/2
Seen dead bodies or handled dead bodies	2/1
Friends or family murdered or killed by drunk drive	3/0
Romantic partner/child death	1/2
Serious/life- threatening illness	3/0
Received news of injury, illness, or death of someone close	3/0
Military	0/3

One hundred percent reported they had been repeatedly sexually abused (see Table 4). All the participants also report having been physically attacked more than once in their life.

Table 4

THQ: Physical and Sexual Experiences

Variable	<i>n</i> =Yes/ <i>n</i> =No	Repeated?
Forced intercourse, oral, or anal sex	3/0	3/0
Forced sexual touch	3/0	3/0
Other unwanted sexual contact	1/2	1/2
Gun, knife, or weapon attack	3/0	1/2
Injury in attack w/o a weapon	3/0	3/0
Injury in beating, Spanking, or push	3/0	3/0

CHAPTER V

DISCUSSION

All of the current patients had suffered from abuse and neglect. Although recognized for many years by the social work profession as being a “precursor” to later problems, child abuse has historically considered as a separate etiology. For example, child abuse and maltreatment have been linked directly to an individual having distressing cognitive symptoms, and have even gone so far as to suggest the importance of considering it in patients presenting with cognitive complaints (Szabo, Nelson, & Lantrip, 2020).

Implications for Practice

One specific recommendation for such patients has been the consideration of an educational approach for their treatment. More specifically than just an educational approach, a cognitive educational approach that focuses on realistic views of the world and oneself (Ferrajão & Elklit, 2020). What we have known for many years is that those who have experienced abuse have a distorted view of the world and their place in it. In other words, their interaction with others will be more focused on irrational views. Not all victims of child abuse will have cognitive impairments; however, there is evidence that this is more likely to be the case (John, Cisler, & Sigel, 2017).

A history of child abuse has also been found to be associated with post-traumatic stress disorder (PTSD), and other mental health problems. Adolescent females who had been abused were found to suffer from mental health difficulties when compared to

adolescent females who had no history of child abuse (John et al., 2017). Patients who have a history of child abuse are more likely to have suicidal ideation, attempt suicide, and have multiple attempts if they are unsuccessful (Wong, Kuo, Sobloweski, Bhatia, & Ip, 2019).

A history of child abuse can also take a toll on one's physical being. A crucial part of any child's maturation process will be their increased risk for developmental delays (Bengwason & Bancual, 2020). Research also has shown that they are also more likely to develop an eating disorder (Rodgers et al., 2019). This is a much clearer manifestation of a cognitive disconnect that occurs between the individual's perception and the real environment as it exists.

Other research indicates that a person with a significant trauma history may have challenges when it comes to coping with their pain effectively. It is not a question of whether the pain the person is feeling is real but instead if that person has mechanisms in place to cope with their pain to make it tolerable (Spertus, Burns, Glenn, Lofland, & Mccracken, 1999). The potential link to this may be related to those with a history of trauma may have lower coping ability. For example, one study found that patients who had a higher resiliency (i.e., coping ability) score had less intense pain (Newton-John, Mason, Hunter, 2014). An area that few physicians have any knowledge about or will explore as part of their medical assessment (Burns, 2010). Not only is there an identified link between a history of trauma and chronic pain there is also a distinct link between trauma and depression (Tennen, Affleck, & Zautra, 2006).

As the literature suggests, childhood trauma is directly related to an increased likelihood of having pain management issues. As found with the current results, all three

participants had been traumatized by a violent death or disaster of some sort. Although not a clear statistical link, the profile of the current patients, when coupled with the strong association within the literature, would suggest that the Pathways team would benefit in their ability to provide care for their patients, if they shifted their focus to interdisciplinary treatment for the patient who suffers from chronic pain. As found in prior research, an interdisciplinary approach has the greatest chance of success (Goldberg, Pachasoe, & Keith, 1999).

A significant part of caring for a patient is for the clinician to thoughtfully look at and understand all dimensions of the patient's diagnosis. This was proven to be important for the three patients studied in this research. All three came in with different diagnoses and with different histories of different substance dependence. As the literature suggests, it is crucial for the medical team to understand the whole picture and history for each particular patient. As implied by the small number of patients in the current work, their histories are consistent with prior research that illustrates the significant correlation between trauma and the development of adult physical and mental conditions (Brady, 2017).

Implications for Research

Another approach taken by the THQ has been the combining the area of sexual and physical abuse or trauma. As suggested earlier, child abuse has long been considered by social workers as an important marker that results in multiple problems in later years for anyone who has experienced them. However, the absence of considering this from a "trauma" perspective has resulted in potential limitations for the practicing social worker.

The social work profession has long considered the effects of child abuse and its relationship to later pathology. Research suggest that history of abuse makes young boys more violent and studies suggest more research be done in juvenile detention centers to search for a link between violent behavior and a history of child abuse (Lahlan, van der Knaap & Bogaerts, 2013). More recent findings suggest the possibility of a combination of trauma and abuse affecting the patient differently than just abuse by itself. As was seen in the patients with the current work, abuse and neglect have been linked to being “damaged” in adulthood. (Johnson, E, & James, 2016). By *damage*, the researchers are referring to psychiatric disorders, increased rates of substance abuse, and relationship difficulties and the likelihood that they will be the victim of other traumatic experiences. Another aspect to this area of research has shown that child maltreatment leads to more adults having developmental disabilities (Teska, 2018). Disabilities that again have been linked to an increased likelihood of additional forms of trauma.

What these researchers do not specifically mention is that there may be other aspects of trauma that accompany the child abuse, or neglect. In the current study, the THQ identified multiple forms of other trauma that may have resulted from the earlier childhood experiences. This does not suggest a causal relationship may exist between the two, but rather that the damage and developmental disabilities have an equally fundamental influence on the experiences of the effected adult. In other words, one might assume that there is not a clear distinction of which aspect of trauma affected the patient’s pain the most or if it was a combination of multiple experiences. All of this to say, there may be more to be explored in an individual’s trauma experiences than simply whether they have a prior history of being abused or neglected or have had been

victimized by other forms of trauma. A question that could only be addressed with a much more in depth and larger study.

Limitations

The proposed research had significant difficulty in having on adequate opportunity to collect on an appropriate number of participants. Given the multiple problems encountered only allowed for data collection of five days. When coupled with the national COVID-19 virus epidemic which limited the hospital referrals provided only an $n=3$ of patients to complete their surveys and allow time for processing to meet thesis deadlines.

Due to the small sample size of three participants, this study does not permit for any form of meaningful statistical analysis. However, it is important to note that these findings will still provide the Pathways Supportive Care and Palliative Medicine team at Hendrick Medical Center potential information to consider. Although there were only three patients who were available to participate in the study, it is important to note that they presented with differing diagnoses, but all had experienced significant trauma. All three patients had been on and were currently on pain medicines such as methadone, dilaudid, and hydrocodone for treatment of their “significant” pain.

There are obviously major issues that limit the discussion and conclusions that can be drawn from this work. The limited number of participants, no statistical analysis, and only the use of one standardized survey presented with multiple concerns. However, the most important aspects of this work are that: (i) the findings from the literature are consistent with the patients that are being seen for pain medication abuse at Hendrick Medical Center, and that they have a significant trauma history, and (ii) the implications

would suggest that additional consideration be given that the palliative care program may want to include a much more thorough trauma analysis as part of their assessment. By doing that, they would then be better prepared to choose the appropriate educational or intervention program for the greatest chances of success.

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- Zelda Foster Conference, NY, 2019

APPENDIX A
IRB Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World
Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
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February 14, 2020

Lauren Grizzard
Department of Social Work
Box 27866
Abilene Christian University

Dear Lauren,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled "History of Trauma in Chronic Pain Patients",

was approved by expedited review (Category 7) on 2/14/2020 (IRB # 20-011). Upon completion of this study, please submit the Inactivation Request Form within 30 days of study completion.

If you wish to make any changes to this study, including but not limited to changes in study personnel, number of participants recruited, changes to the consent form or process, and/or changes in overall methodology, please complete the Study Amendment Request Form.

If any problems develop with the study, including any unanticipated events that may change the risk profile of your study or if there were any unapproved changes in your protocol, please inform the Office of Research and Sponsored Programs and the IRB promptly using the Unanticipated Events/Noncompliance Form.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs