



*PSYCHOLOGY IN HEALTHCARE: 'The ambulance at the **top** of the cliff.'*

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*'The ambulance at the bottom
of the cliff...'* (Joseph Malins, 1895)

*= a failure of timely
intervention resulting in
unnecessary casualties and
consequences .*

In Healthcare, timely intervention:

- Improves health outcomes for individuals
- Reduces longer-term healthcare costs
- Minimises lost productivity

Examples from

1. Elder care in the community
 2. ACC Pain Management Service
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SUPPORTING OLDER PEOPLE IN THE COMMUNITY

'Mary'

77, living on her own, "positive... independent... lived a full life"

Various stressors, low mood, "just getting old... carry on..."

2013 – Older Persons' Mental Health

2015 – relapse, wait listed for OPMH

Age Concern contacted

Treatment: weekly/2 months, psych-education, CBT, support

Outcome: no requirement for further input, off the wait-list



Age Concern Survey:

90% - useful to have access to psychological support

70% - would not know where to seek help

Mild to moderate issues under-resourced...

Implications: unnecessary casualties & consequences





- **WORKPLACE HEALTH**
- **INJURY MANAGEMENT**
- **REHABILITATION**

Help for the injured employee to stay at work or get back to work includes input from:

- Occupational therapist
 - Physiotherapist
 - Psychologist
 - Acupuncturist
 - Rehabilitation physician
 - Social worker
 - Dietician
 - Speech & language therapist.
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Pain is

"..an unpleasant **sensory and emotional** experience associated with actual or potential tissue damage, or described in terms of such damage."

(International Association for the Study of Pain / WHO)

Pain is processed in the brain

Big role for psychology in pain !

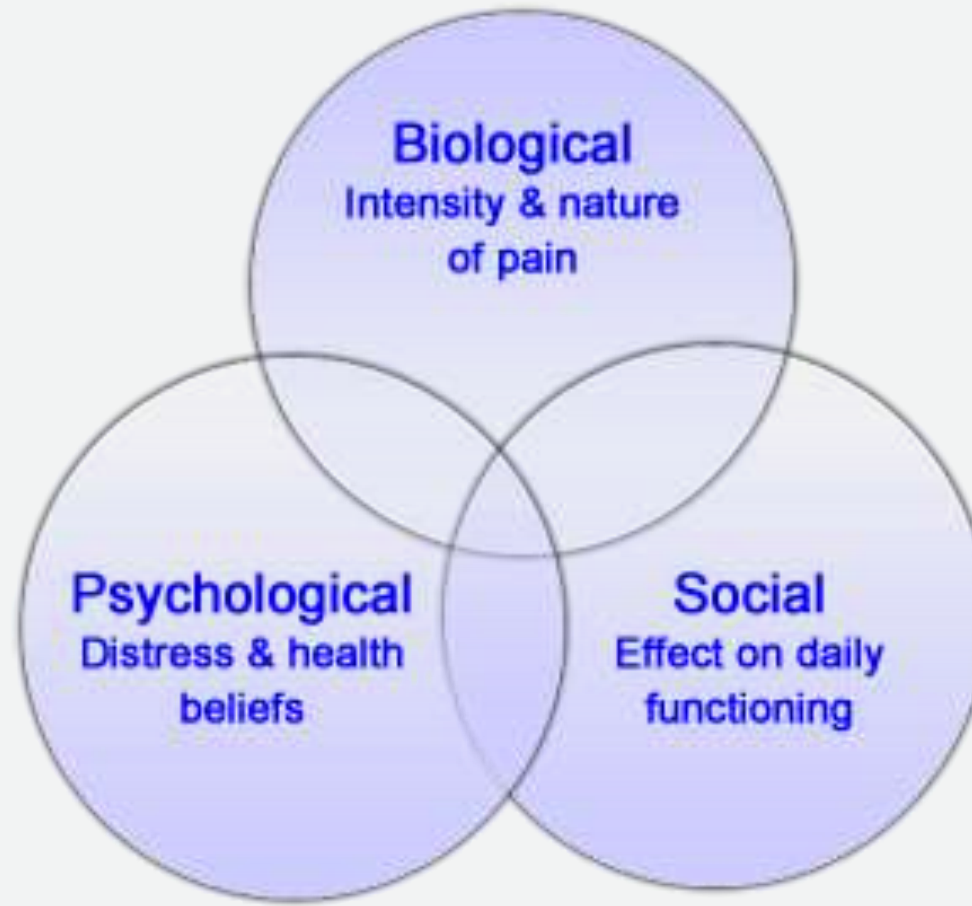




Biopsychosocial model of pain

broadens the view of pain and the experience of pain

**PAIN
MANAGEMENT
SERVICE**





PAIN MANAGEMENT SERVICE



Yellow Flags-Psychological Indicators

Yellow flags are psychosocial indicators suggesting an increased risk of progression to long-term distress, disability and potential drug misuse. They include the patient's attitudes and beliefs, emotions, behaviours, and family and work place factors

Work place

- belief that all pain must be abolished before attempting to return to work or normal activity
- expectation/fear of increased pain with activity/work
- poor work history
- unsupportive work environment

Attitudes and beliefs

- belief that pain is harmful, resulting in avoidance and poor compliance with exercise
- catastrophising, thinking the worst
- misinterpreting bodily symptoms
- belief that pain is uncontrollable
- expectation of 'techno-fix' for pain

Social/family

- overprotective partner/spouse
- socially punitive partner/spouse
- lack of support to talk about problems

Behaviours

- passive approach to rehabilitation
- use of extended rest
- reduced activity with withdrawal from activities of daily living
- avoidance of normal activity
- impaired sleep because of pain
- increased intake of alcohol or similar substances since the onset of pain

Affective/emotions

- depression
- feeling useless
- irritability
- anxiety about heightened body sensations
- disinterest in social activity



'Jenny'

56 yr old, works part time, recently widowed

Assessment

High pain catastrophising, Low pain self-efficacy
Moderate anxiety/stress, Low depression



Careful history taking

Fell off a ladder, injured back and hip

Psychosocial factors

- Recent loss of partner
- Anxiety about returning to work (how to manage pain?)
- External locus-of-control

Medical history

Coping strategies: adaptive / maladaptive

Protective factors

Stage of 'readiness' for change



'Jenny'

Treatment: a team approach:

- Pain medication
- Pain education and pain management strategies
- Breathing & Mindfulness
- CBT – challenge unhelpful thoughts/ treat anxiety/address beliefs about pain, etc.
- Positive psychology – self compassion, use of strengths...
- Grief & loss support
- Lifestyle factors: exercise is the best drug!



Outcome measures:

- ePPOC: DASS, PCS, PSEQ
 - self-reported minimal / **no pain**
 - fewer medications
 - back to work and coping well.
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What if Jenny receives only pain medication and physiotherapy ?

Psychological and emotional components of pain go untreated.



Jenny's brain continues to make processing errors – sending threat messages in the absence of threat; in other words, pain in the absence of tissue damage.

Resulting in unnecessary distress and probable long-term disability.

Sample evidence for the efficacy of self-management for pain

"People who are actively involved in managing their pain on a daily basis have less disability than those who are engaged in passive therapies, such as taking medication or surgery."

Cousins & Gallagher (2011) Chronic and Cancer Pain

"Pain self-management training increases self-efficacy, self-management behaviours and pain and depression outcomes."

Damush et al (2016) European Journal of Pain

"A multidisciplinary approach is the future... A team approach accounting for several aspects within the bio-psychosocial model is more likely to help individuals with chronic LBP compared to standard care alone."

Vittoula et al (2018) Pain Therapy

To summarise

For Mary

- Timely return to functionality
- Useful knowledge and strategies

For Jenny

- Timely return to functionality
- Useful knowledge and strategies
- No progression to significant chronic issue

- Improved wellbeing
 - Continued contribution to society - family, community, work
 - Reduce long term demands on secondary services

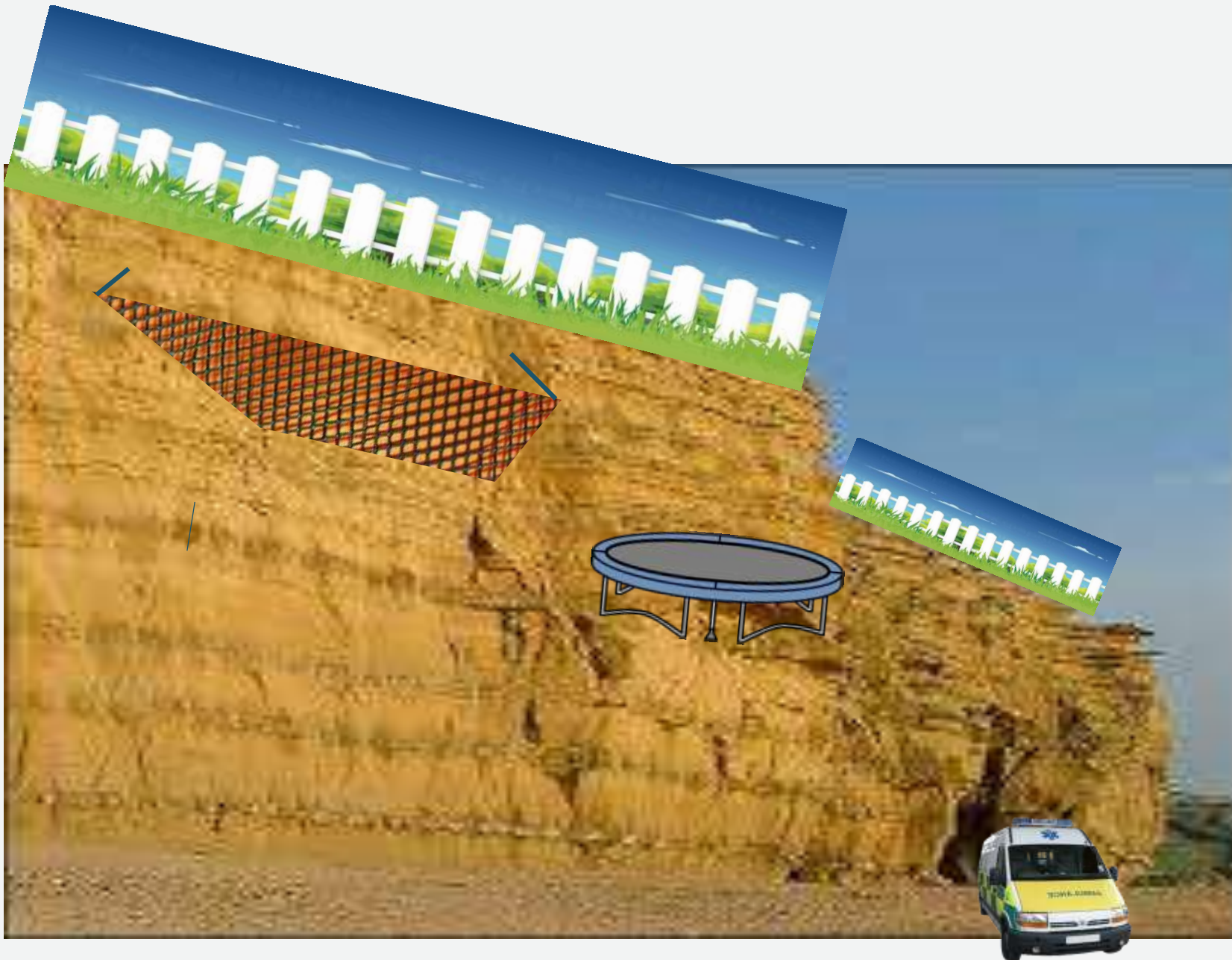




Psychology in healthcare



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