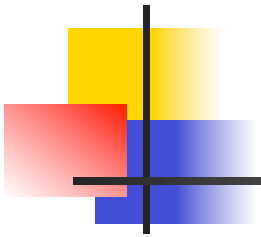

Chris Basten

PSYCHOLOGICAL NEEDS IN PEOPLE WITH AN AMPUTATION

Psychological needs depend on many factors, incl. …

- Time since amputation*
- Reason for amputation
- Other comorbidities
- Expectations about functioning
- Premorbid functioning

Common Reactions
Livneh and Antonak (1997)

- Shock or Impact
- Anxiety and Distress
- Hostility (internalised then externalised)
- Depression and grief; sadness for losses
- Acknowledgement
  (includes early acceptance)
- Reorganisation or reconstruction

Psychological needs depend on many factors, incl. …

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Psychological needs depend on many factors, incl. …

- Time since amputation
- Other comorbidities
- Expectations about functioning
- Premorbid functioning
- Reason for amputation

Trauma (as opposed to PVD)

- PTSD quite common*
- Lower mean age
  - Ergo greater impact on body image, identity, sexuality, and vocational functioning.
- Often have better baseline health and capacity to adapt vocationally

Post-traumatic stress

1. Re-experiencing (intrusive memories and images, distress on reminders, nightmares)
2. Avoidance (thought suppression, avoids reminders and situations, substance use…)
3. Arousal and Anxiety (sleep disturbance, impaired memory and concentration, startle response, difficulty relaxing)

-> Can affect willingness to do treatment

Post-traumatic stress

- Most common after an accident
- Approx 10 to 50% in the first few weeks
- Increases after discharge from hospital
- Up to 70% at six months (e.g. Copuroglu et al (2010).

Reason = Trauma

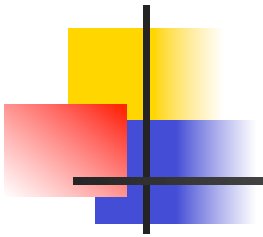
- PTSD quite common
- Lower mean age
  - Ergo greater impact on body image, identity, sexuality, and vocational functioning.
- Often have better baseline health and capacity to adapt vocationally

Peripheral Vascular Disease

- Presentation affected by:
  - Older mean age
  - Possible impaired cognition
  - Possible low baseline of activity and independence
  - Medical comorbidity (vision, diabetes, etc…)
  - Past health behaviours and tmt adherence

Tumours and Disease

- Also facing life-threatening illness and uncertain prognosis
- More likely to view the amputation as life-saving surgery
- Still distress though about losses and changes.



STEPS WE CAN ALL USE TO HELP OUR CLIENTS

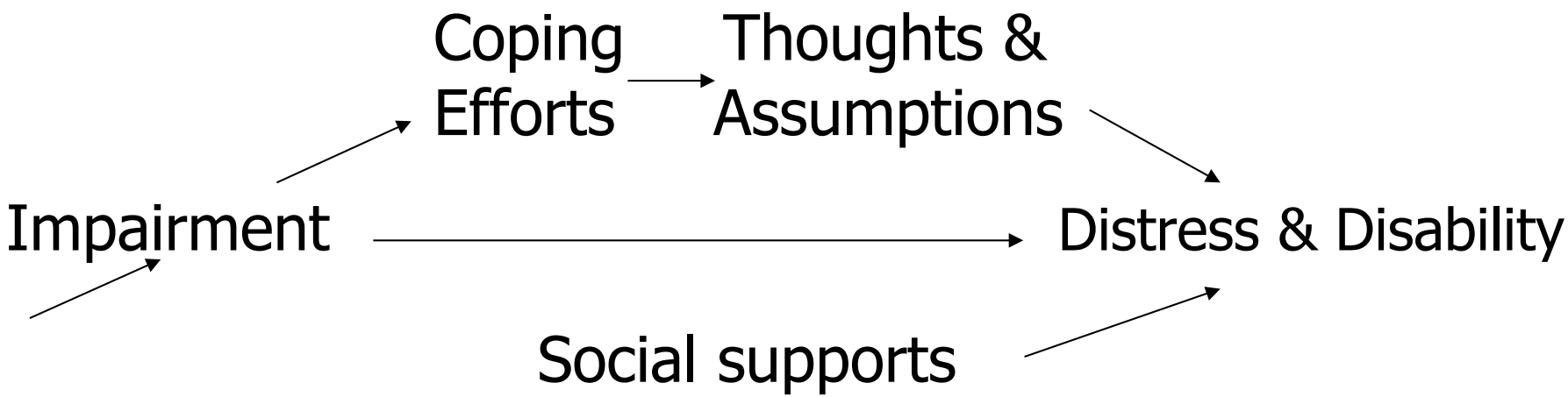
What leads to emotional distress?

- **A causal model**

Impairment ⟶ Distress & Disability

Models and formulations

- **Biopsychosocial Model**



Sequencing Interventions

- Address basic needs first (e.g. acute distress; uncertainty; anxiety, trauma-related stress)
- Only then consider addressing longer-term issues (as chronicity starts to establish)
- Activate early

A. Normalise and Validate

- Explain that it is universal and inevitable that they will feel down and demoralised at times
- Encourage appropriate expression of emotion
- Discuss how coping and adapting is also universal
- Discuss how working with a social worker, counsellor or psych' is also common and helpful

B. Education and Hope

- Educate about what to expect in terms of pain, return of function, over what time periods
- Discuss the goals that they value the most
- Set immediate and medium-term goals to deliver a sense of meaningful progress
- Introduce to other amputees doing well

C. Increase confidence

- Examine why their confidence might be low and challenge if appropriate.
- Start with very small goals; “success experiences”
- Do “behavioural experiments”
- Ask them if they would like to hear about or meet other clients
- Give information and resources

D. Focus on Strengths

- In assessment, take a lifespan history of adversity and challenges that they have overcome, problems solved, achieved things when they were unsure.
- This yields an understanding (1) that they have coped before and (2) what their coping strategies are and (3) that the health professional has respect for them

E. Set goals and teach goal-setting

- S Specific; well-defined
- M Meaningful to the individual
- A Achievable
- R Realistic
- T Time specific

- And, consistent with readiness for change principles.

The Magic wand question

F. Treat Pain

- Improves mood
- Improves prosthesis use
- Increases mobility

Etc…

G. Solve Problems

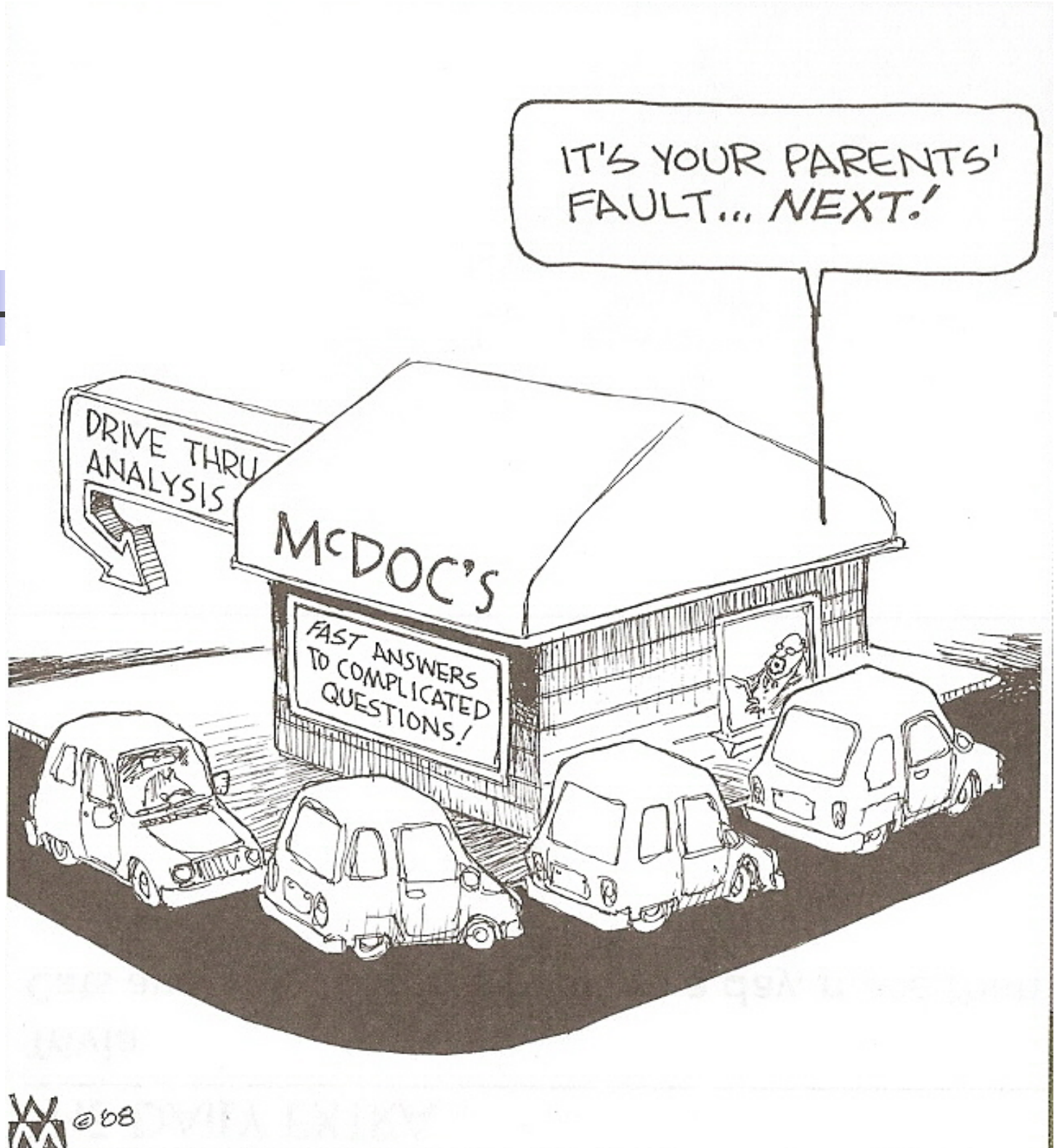
- Identify the issues or problems that are causing that client distress or worry
- Actively assist
- Also teach and role-model problem-solving skills
- Aids a sense of alliance with health professional and future adherence.

H. “Socialise” into the practice and attitude of rehab

- Educate about the essential ingredients of rehabilitation
- Responsibility and locus of control
- Tolerating short-term pain and discomfort
- Ideas like
  - Acceptance
  - Adaptation and compensation
  - optimisation

J. Encourage them to accept a mental health referral

- Normalise (but don't trivialise)
- Help explain that there are ideas and strategies that an expert has up their sleeve that the average person would not think of *


IT'S YOUR PARENTS' FAULT... NEXT!
DRIVE THRU ANALYSIS
McDOC'S
FAST ANSWERS TO COMPLICATED QUESTIONS!
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  - Retiree - financial planner
  - Health problem - doctor

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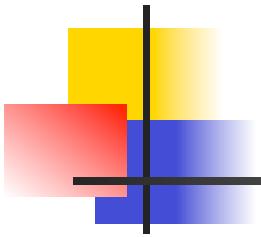
When to refer?



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