Psychology Pointers for The Non-Psychologist

9th Annual Current Concepts in SCI Rehab Conference

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Learning Objectives:

- Review scope of practice and practice expectations for non-psychologists
- Differentiate between grief, normal adjustment, and psychiatric presentations.
- Discuss behavioral and other nonpharmacological interventions for non-psychologists

Scope of Practice for Non-Psychologists

- Know the limits of your training and discipline
- If you aren't sure, ask
- Call or text for help (#988 or Resolve Crisis Line)

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What are *your* triggers or warning signs?

- Patient refusal
- Fear of holding boundary
- Impostor syndrome
- Physical exhaustion
- Expectations around billing quotas

Today's Toolbox

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Different Stages

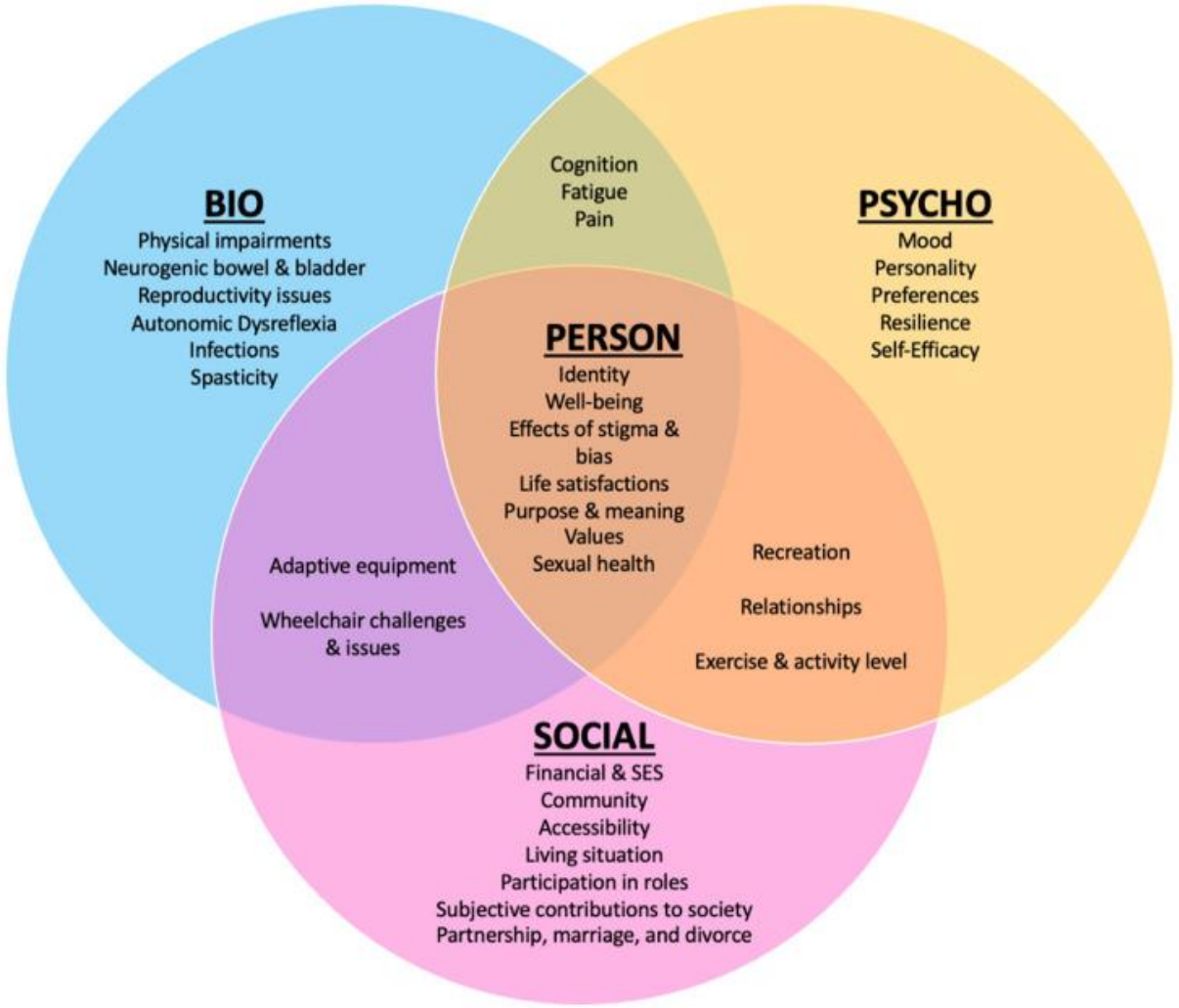
Acute

- Shock of trauma or diagnosis
- Crisis/survival mode- anxiety, exhausted, sense of numbness
- Relief in surviving catastrophic events
- Hope/belief in full recovery
- Regret

Inpatient Rehab-Outpatient

- Hope/belief vs. questions about the future
- Increasing awareness of functional loss especially with more demanding tasks from staff
- Numbness may be wearing off
- Denial/ repressed feelings
- Anger/frustration and/or unreasonable demands directed at staff
- Anxiety/fear/depression start to emerge
- Family members may not agree on care or may not be available for support

Biopsychosocial Impact of SCI (Budd et al., 2022)



Common Emotional Experiences post-SCI

- **Grief or Bereavement of parts of life and body lost due to SCI**
- **Difficulty with adjustment to disability**
- **Sadness**
- **Depression**
- **Anxiety or new worries**
- **Trauma or PTSD**

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Adjusting and Adapting to Disability

- Grieving through coping and rebuilding
- Openness to activities that align with level of functioning
- Building their support team
- Adopting disability identity

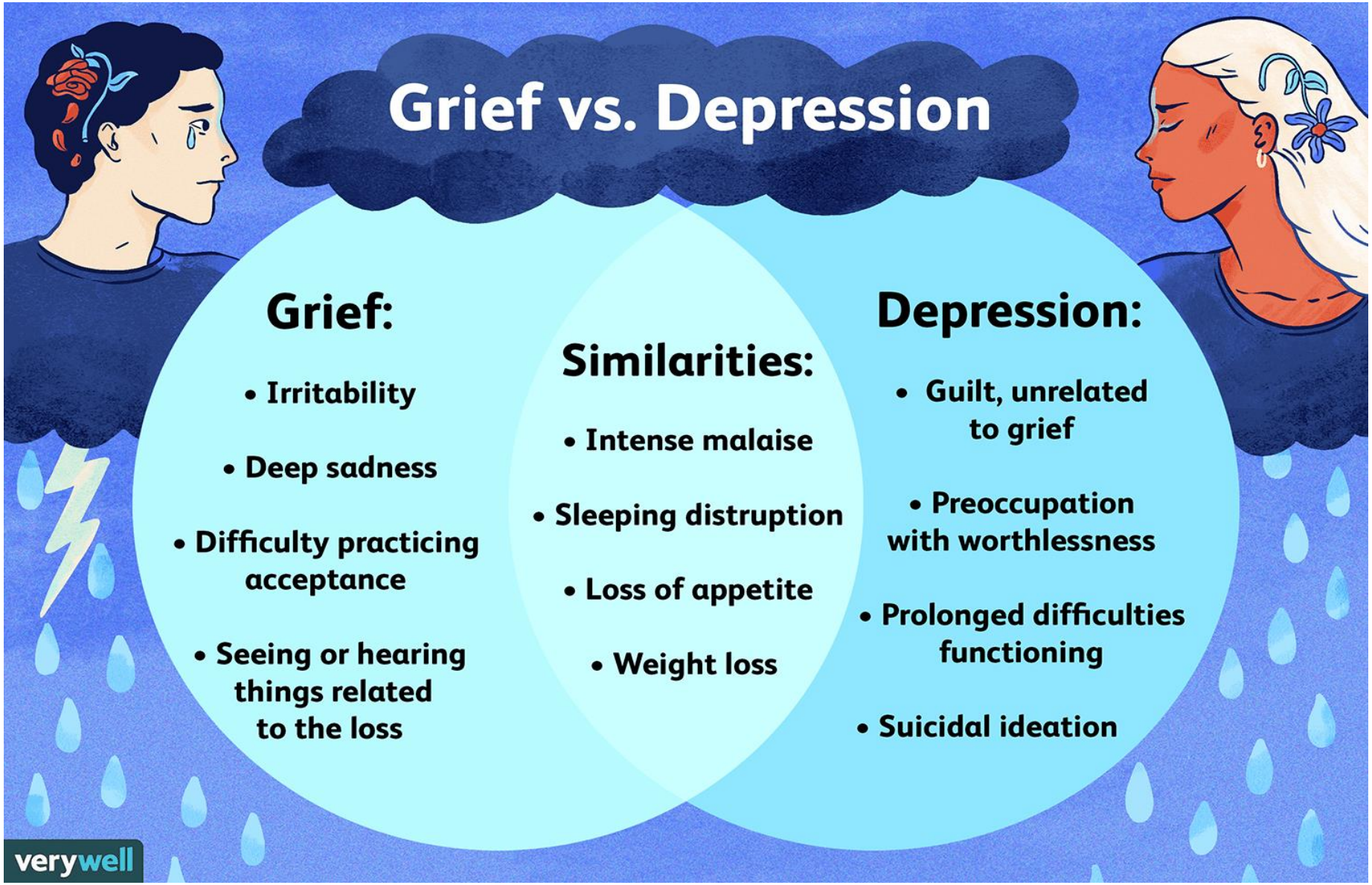

Image from: https://recoveryranger.com/wp-content/uploads/2023/03/grief-and-depression-1067237_final_withlogo_revised-f3b25faac3b9428c989ab9f2a216d9ed.png

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What grief looks like

- Overly optimistic comments and dismissive of questions about sadness or worry
- Strong front/Teflon persona
- On the go mentality
- Detachment from others
- Anger or bitterness, quick to react
- Difficulty accepting status quo
- Passive death wishes
- Difficulty finding joy
- Guilt that this could have been prevented

What grief and normal adjustment are NOT

- Persistent interference in functioning
  - Wanting to stay in bed
  - Not participating in therapies
  - Not engaging w/family
  - Rehab plan revolves around managing behaviors/emotional responses

One might think it's depression, but in fact, it is…

- **Apathy**
- **Abulia** *(particularly with frontal lobe injury)*
- **Catastrophic Reaction**
- **Pseudobulbar affect**
- ***Aprosodic speech***
- **Behavioral disturbances due to the brain injury**
- **General Physical Slowness**
- **Disorders of facial expression**

Case Example 1

Myra

27y college student with a T7 AIS D injury. Myra has limited family support and has become increasingly more isolated after her injury. At her PT appointments, she comments on her loneliness, sadness, and sometimes cries mid-session mostly due to frustration with her current level of functioning. Myra works remotely, but wishes that she could return to her job as a barista or that she could get back into swimming as these hobbies brought her immense joy pre-injury. Myra denies changes to her sleep or appetite, but reports that her pain has been worse.

Case Example 2

Duran

56y with paraplegia who was injured 2/2 MVA. Duran's romantic partner of 27 years left him 4 months ago. He relocated to an apartment complex and spends several nights and weekends socializing with the other residents to avoid being alone. During his medical exam, Duran complains about how inconsiderate others are and appears irritable. He describes himself as quick to anger in the last month, but also comments that drinking helps to take the edge off. Duran's hygiene is also surprisingly poor given he is such a sharp dresser. He comments on not feeling like bathing as much now that he doesn't have someone to impress or much to look forward to these days. On his medical exam, Duran describes his sleep as "awful" and chuckles when you ask about appetite because he's gained 15lbs.

Anxiety & SCI

"Up to 45% of injured individuals reporting excessive worry, fear or panic,[1] contributing to a high risk of experiencing disorders such as generalized anxiety (GAD)"-Le & Dorstyn, 2016

Common sources of anxiety after SCI:

- Response to traumatic etiology of injuries
- Autonomic changes and other physiological changes
- Fear around changes to finances, relationships, self concept
- Fear of falling, recurrent injury, worsening of new medical symptoms and conditions
- Increased perceived and actual helplessness

PTSD Symptoms

- Pre-existing traumatic experiences
- Avoidant coping
- Need for creating sense of safety

Toolbox

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Managing Patient Emotions

- Validating patient experience
- Normalizing through psychoeducation
- Hearing and listening to the patient's concerns

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Tips on how to respond to emotional distress (Barton, 2012)

1. Show the patient that you are listening.
2. Let the patient know that you have heard what they're saying and that you understand (reflective listening). If you don't understand, let them know.
3. Try to concentrate on what the patient is trying to communicate to you. Focus on how the patient is behaving, as well as what he/she is saying.

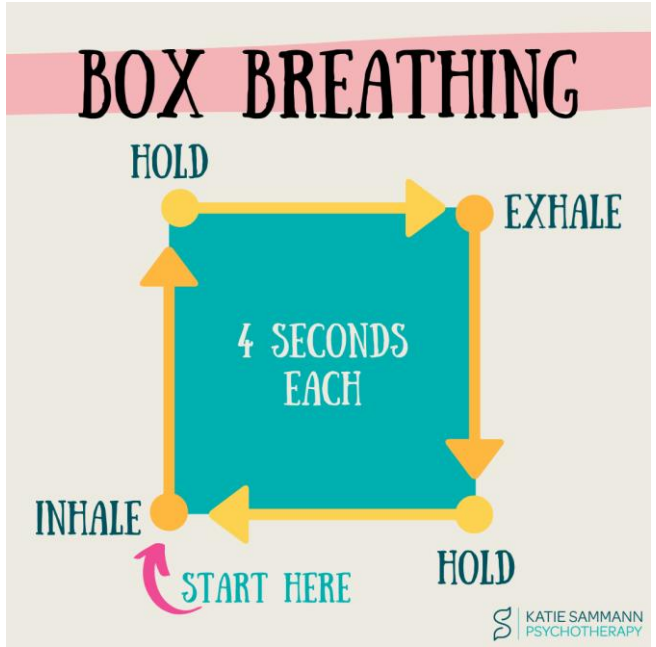
Tips (continue)

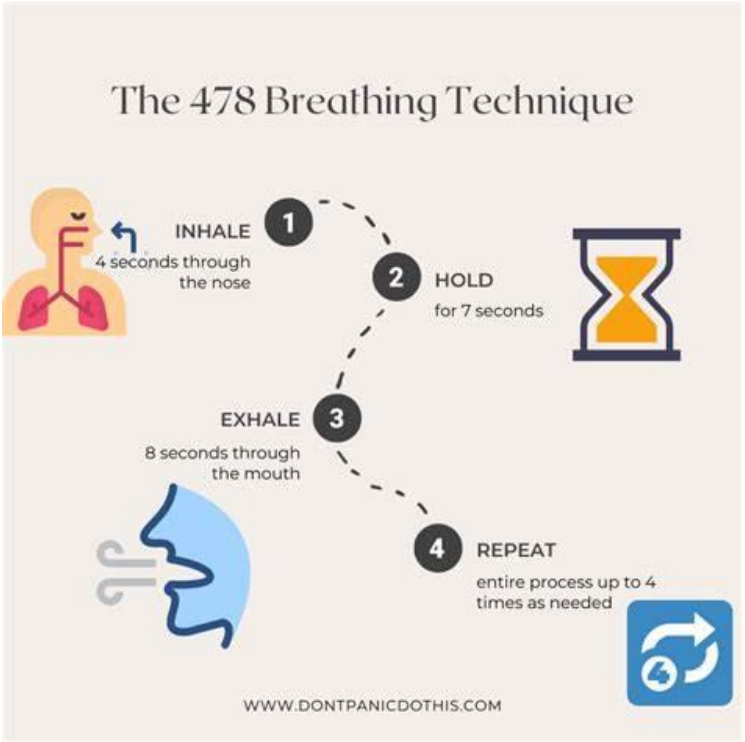
4. Remember, if a patient is distressed or crying, acknowledge the distress, do not avoid it. Sometimes, the last thing people want to hear is, “Everything will be alright.” Of course, people want reassurance, but they also want their distress acknowledged and validated
5. Be mindful of nonverbal communication you display, eye contact, open body posture, so the patient knows that you are interested in what he/she is communicating to you.
6. Don’t rush your patient but letting them know of time left in session to work on goals and offering choices.
7. Try to limit managing distressing emotions to no more than 5-7 min of scheduled appointment.

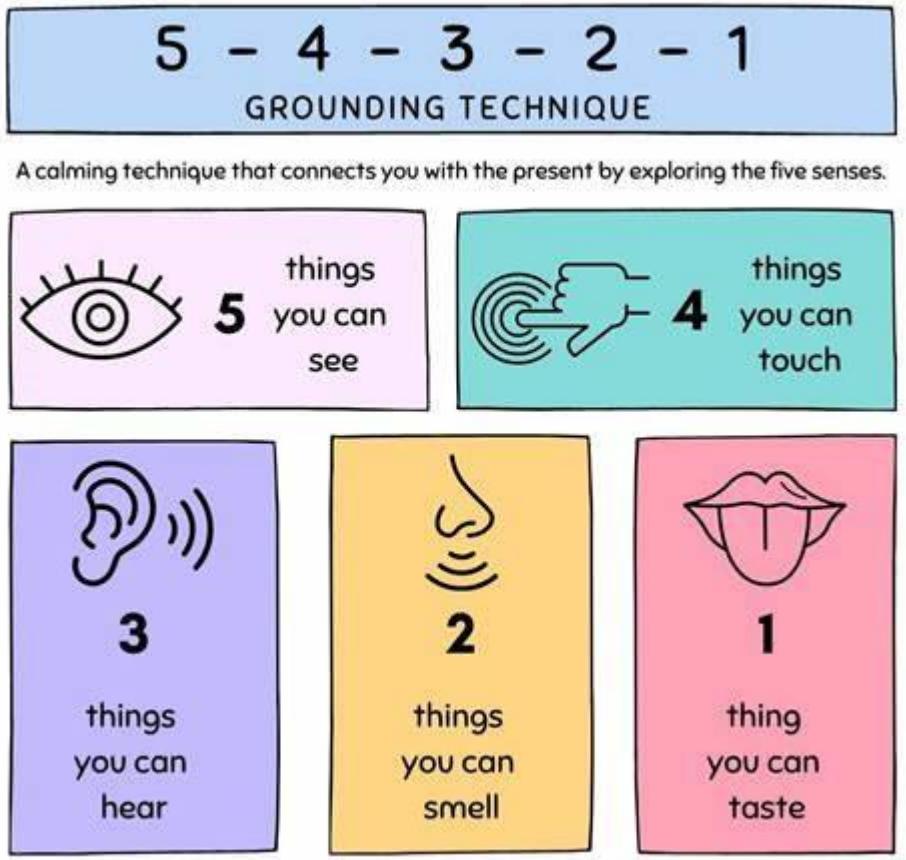
Addressing Distress, Trauma, Sensory Overwhelm

- Avoid crowded and noisy spaces
- Ensure sufficient rest breaks and hydration
- Introduce structure to daily activities and schedule by reviewing plan for that day's appointment (predictability)
- Offer choices
- Offer/use music when appropriate
- Move patient to quieter space if noise is overstimulating
- Offer flexibility around scheduling
- Emphasize aspects of environment that offer safety

Nervous System Regulation Strategies







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Case Examples

Case 1: Myra

Case 2: Duran

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Setting the Boundary

Self-Care Approaches

- **It's okay to set boundaries!**
- **Remember your triggers/hot button issues and seek support when these arise**
- Lean on your team
- Take real breaks
- Celebrate the wins and remember past successes
- Ask for help

The STOP Skill

S Stop

T Take a step back

O Observe

P Proceed mindfully

Linehan, M. M. (2015). DBT® skills training manual (2nd ed.). New York, NY, US: Guilford Press.

Psychotherapy Academy

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Bad Day/Week Routine

- Something Physical
  - Exercise, Dance, Yoga, other forms of movement
  - Comfortable clothing, bath/shower with favorite bath wash
  - Satisfying Meal, Hydration
- Something that involves other people
  - Connection with colleagues, friends, family
- Something Emotional
  - Time to cry, rant, scream, vent
- Opportunities to Laugh
- Time outside in nature

Support

- Local Support Groups/caregiver support groups
- PA disability rights network
- United Spinal Association www.unitedspinal.org
- Amputee Coalition www.amputee-coalition.org
- Phoenix society for Burn Survivors www.phoenix-society.org

- Pain Connection www.painconnection.org
- Pitt Center for Mindfulness and Conscious Studies https://mindfulnesspitt.org/
- UPMC Department of Integrative Medicine http://upmc.com/Services/integrative-medicine/Pages/default.aspx
- Askjan.org
- https://pbavoices.org/
- Office of Vocational Rehabilitation

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Questions?

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