

Rehabilitation Research Review™

Making Education Easy

Issue 46 – 2018

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Abbreviations used in this issue

ABI = acquired brain injury
SCI = spinal cord injury
TBI = traumatic brain injury

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Rehabilitation Research Review



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Welcome to issue 46 of Rehabilitation Research Review.

One of the papers covered in this issue of Rehabilitation Research Review includes a qualitative investigation into factors which influence satisfaction with outpatient musculoskeletal physiotherapy. The findings suggest that patient satisfaction in physiotherapy is a multidimensional phenomenon and that limiting patients' improvements to clinical outcomes (e.g. range of motion) fail to fully satisfy patient satisfaction. The article recommends that healthcare services consider patient satisfaction as a fundamental indicator of quality care, which will lead to its continual assessment and critical evaluation, by both clinicians and those in management.

Five of the papers are drawn from the recent Asia-Oceanian Conference of Physical and Rehabilitation Medicine, held in Auckland. This year's conference theme was the "State of Art of Rehabilitation Medicine: North to South, East to West".

I hope that you find the research in this issue useful in your practice and I welcome your comments and feedback.

Kind regards,

Associate Professor Nicola Kayes

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Relationships and the transition from spinal units to community for people with a first spinal cord injury: a New Zealand qualitative study

Authors: Bourke JA et al.

Summary: These researchers conducted interviews with 19 people with SCI at 6 months after their discharge from the spinal rehabilitation unit. They discussed the ways in which their injury had affected their relationships during their transition home. Framework analysis identified 3 themes that encapsulated how the participants described their relationship experiences after returning home:

- Role Disruption concerned the changes in participants' pre-SCI family/whānau relationships in response to disruption of previously understood parameters of engagement.
- A Balancing Act explored how participants met the challenge of having to renegotiate formerly understood parameters between them and their whānau.
- The Stranger in My/Our Room focused on the introduction of support workers into the lives of the participants and those of their family/whānau. The participants spoke about having to negotiate the parameters of this new relationship with the support workers.

Comment: This is an interesting NZ-based study. It offers a useful insight into the complexities of managing roles and relationships in the context of SCI following transition home. Indeed, how successfully people navigate these relationships in the context of uncertainty and threats to one's own personhood may be critical to outcome. There is much one could discuss with reference to this paper. However, I will draw attention to two aspects. The first is with respect to the theme of *Role Disruption*. In this paper, there is a self-reported impact on parental roles following discharge home. However, what do we know about the immediate and ongoing impact these changes in parental roles and family dynamics have on children in the family and the extent to which children may exert influence over parental relationships? The impact of parental injury or illness on children in the family is rarely given attention. A master's student of mine explored this in the context of parental TBI (see <http://aut.researchgateway.ac.nz/handle/10292/10498>). She found that children play an active role regulating family life and relationships in the context of injury and argued that adult rehabilitation services need to pay attention to children in the family – both to provide them with support, but also in recognition of the important role they may play in recovery for the injured person. Second, the third theme *The Stranger in My/Our Room* offers a unique perspective into the introduction of support workers into the home and the dynamics of navigating that relationship. The authors make the point that the nuances and complexities of this relationship are not fully realised until people with SCI are discharged home and argue for the need for ongoing community support following transition.

Reference: *Disabil Health J.* 2018 Sep 14. [Epub ahead of print]

[Abstract](#)

Independent commentary by Associate Professor Nicola Kayes

Associate Professor Nicola Kayes is Director of the Centre for Person Centred Research at Auckland University of Technology. Nicola has a background in health psychology and as such her research predominantly explores the intersection between health psychology and rehabilitation. **For full bio** [CLICK HERE](#).



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A study of the influence of cognitive complaints, cognitive performance and symptoms of anxiety and depression on self-efficacy in patients with acquired brain injury

Authors: Brands IM et al.

Summary: This study from The Netherlands examined how self-efficacy influences how patients manage brain injury-specific symptoms and cognitive performance, subjective cognitive complaints, and symptoms of anxiety and depression. The researchers recruited 122 patients (mean age, 54.4 years) with recently acquired brain injury (mean time since injury, 14.1 weeks) from general hospitals and rehabilitation centres. All were assessed at discharge home from inpatient neurorehabilitation or as they began outpatient neurorehabilitation after discharge home from acute hospital. The participants completed the Traumatic Brain Injury Self-Efficacy Questionnaire and undertook the Symbol Digit Modalities Test, which assessed their objective cognitive performance. The self-rating form of the Dysexecutive Questionnaire (DEX-P) was used to assess cognitive complaints, while scores on the Hospital Anxiety and Depression Scale measured anxiety and depression symptoms. Patients with lower self-efficacy had significantly higher levels of subjective cognitive complaints ($\beta = -0.35$; $p = 0.001$) and symptoms of anxiety and depression ($\beta = -0.43$; $p < 0.001$), whereas no such association was seen between self-efficacy and objective cognitive performance ($\beta = 0.04$; $p = 0.53$). Furthermore, no significant correlation was observed between objective cognitive performance and subjective cognitive complaints ($r = -0.13$; $p = 0.16$).

Comment: Self-efficacy (or in this case, confidence in one's own ability to manage brain-injury specific symptoms) is an important predictor of outcome across a diverse range of populations and contexts. As such, exploring factors associated with self-efficacy and developing interventions targeted at self-efficacy has become a widely researched topic. It is interesting to see that while there was no association between an objective measure of cognitive performance and self-efficacy, self-reported cognitive performance accounted for 42% of variance in self-efficacy! Conceptually, this finding is possibly not surprising, given both variables are tapping into one's personal beliefs. It is also important to remember that these findings cannot attest to there being a causal relationship between the two variables – in that, it is equally plausible that low self-efficacy contributes to lower perceived cognitive performance. Nonetheless, it does highlight the power of one's own beliefs and perceptions. Indeed, this is yet another example of the role that social and psychological consequences of injury play in recovery and adaptation. However, this remains an aspect not well addressed in routine practice.

Reference: *Clin Rehabil.* 2018 Aug 31. [Epub ahead of print]

[Abstract](#)

Predictors of recovering ambulation after hip fracture inpatient rehabilitation

Authors: Cecchi F et al.

Summary: This Italian investigation sought to identify predictors of rehabilitation failure in patients recovering ambulatory status during intensive inpatient rehabilitation for hip fracture. The study enrolled 352 such patients (mean age, 83.9 years), 1 of whom died and 6 were readmitted to acute care hospital. Referrals to high- or low-care settings were determined by the total score on the Cumulative Illness Rating Scale (CIRS); 34 patients with CIRS scores ≥ 19 required high-care intensive rehabilitation and 318 with CIRS < 19 required low-care. The median length of stay (LOS) in the rehabilitation programme was 22 days. Most patients ($n = 334$) were discharged back home; median daily functional gain (modified Barthel Index score divided by LOS) was 1.3. A high proportion of patients (84%) had recovered ambulatory status on discharge. Poor outcomes were predicted by older age, a higher level of comorbidity, having a urinary catheter, impaired trunk control, worse cognitive and functional status on admission, and pre-fracture disability. The only factors that predicted rehabilitation failure on discharge were higher comorbidity and an impaired ability to communicate at admission.

Comment: There are several findings of note in this study that may have important implications for inpatient rehabilitation following hip fracture: 1) *Comorbidity as a key predictor of recovering ambulation* – multi-morbidity is almost inevitable, given hip fracture is common in the elderly. Yet, it is something we fail to account for or address well in practice. In NZ, this is potentially complicated by the fact that it is one of those boundary issues for the Accident Compensation Corporation (i.e. where the injury may be covered, but not the comorbidity). The authors of this paper argue that we should expect and address complexity in this population as standard practice – I would agree! 2) *Communication disability as an independent predictor of outcome* – this is not in itself surprising – it is after all something that is explored in-depth in stroke, where communication impairment is a common consequence. However, communication disability is not something we routinely pay attention to in the context of hip fracture. Indeed, it is a good reminder to ensure that supported communication techniques are embedded into routine practice across populations and contexts rather than something that is siloed to working with particular diagnostic groups. 3) *The regression model in this case only accounted for 24% of variance in recovering ambulation.* Essentially this means there remains a number of unidentified variables that may contribute to outcome in this population. It is important to note that this research only captured clinical and functional indicators. It is likely that social and psychological factors play an important role here also.

Reference: *BMC Geriatr.* 2018;18(1):201

[Abstract](#)

The social networks of New Zealand patients with multimorbidity and the work of those nominated as their 'significant supporters': an exploratory study

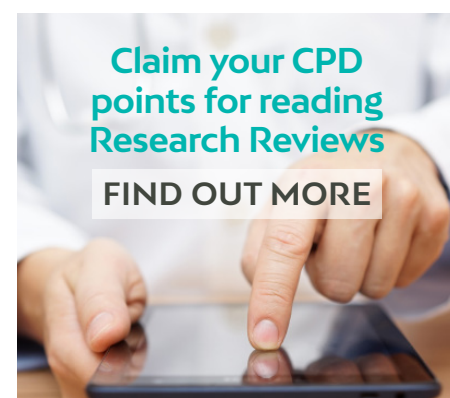
Authors: McKinlay E et al.

Summary: This exploratory study involved 10 people with multimorbidity, each of whom nominated someone from their social network that they considered was providing significant support. These included 3 'lay' supporters (sister, wife and daughter) and 7 'professional' supporters (exercise physiologist, GPs, nurse, medical specialists). Each supporter was interviewed by a researcher seeking information about the experience of providing support and how that supporter viewed the patient's social network. The study classified activities described by the supporters into the categories described by Vassilev et al. (2013), who conceptualise 3 domains of chronic illness work: "illness (specific) work" (work related to taking medications; understanding symptoms; making appointments), "everyday work" (tasks of housekeeping and repairing; occupational labour; child rearing; support and activities related to diet and exercise, general shopping and personal care), and "emotional work" (work related to comforting when worried or anxious about everyday matters, including health, well-being and companionship. It also includes a biographical dimension associated with the reassessment of personal expectations, capabilities and future plans, personal identity, relationships and biographical events). Both lay and professional supporters talked about examples of each category.

Comment: This research was undertaken in NZ and offers insight into the work undertaken by both lay supporters and professionals for people living in the context of multimorbidity. Each participant was invited to identify a nominated supporter "who is important to helping them stay healthy". Interestingly, seven of ten participants nominated a professional supporter, highlighting the important role professionals play in the lives of people living with long-term conditions. Importantly, the work of professionals was not limited to illness-related work, but they also routinely engaged in everyday work (activities aimed at enabling people to successfully live at home and maintain engagement in employment or other meaningful activities) and emotional work (often through the development of quality and enduring therapeutic relationships).

Reference: *Health Soc Care Community.* 2018 Sep 2. [Epub ahead of print]

[Abstract](#)



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Determinants of patient satisfaction in outpatient musculoskeletal physiotherapy: a systematic, qualitative meta-summary, and meta-synthesis

Authors: Rossetini G et al.

Summary: This review includes data from 11 clinical English language studies published up to March 2017 that sought to determine how individual patient factors influence satisfaction with outpatient musculoskeletal physiotherapy. The reviewers identified 6 overarching themes, including: clinical outcomes; physiotherapist features; patient features; physiotherapist-patient relationship; treatment features, and healthcare setting features. The article suggests that patients' satisfaction with outpatient musculoskeletal physiotherapy is a complex, multidimensional health phenomenon that is underpinned by several inter-related factors.

Comment: This paper is worth a read – it provides a robust qualitative synthesis of perceptions regarding what matters to patients in the context of outpatient musculoskeletal physiotherapy. There are endless things I could pick up and talk about from their findings, but I don't have the space for that. The paper provides a more detailed explanation of each theme and so I encourage you to read the paper in full to get a better sense of the findings. The summary above is only able to provide a global and somewhat superficial overview of the findings. A couple of points I will pick up on: 1) In *physiotherapist features*, the authors articulated the importance of *both* human competence (the way in which physiotherapists engaged with people) and professional competence (technical skills and competence). This comes through in the evidence time and time again, and yet we still have a tendency to place more emphasis on technical competence in education and practice. I am beginning to wonder if the distinction perpetuates the problem. What if we were to argue human competence as a critical component of professional practice – where humanness is an integral part of who we are as professionals, without which we can't be deemed professionally competent? 2) Education was identified as an important *treatment feature*. However, importantly, it was noted that 'education was not a passive transmission of knowledge' but rather a more 'active process' that enabled 'deeper understanding', and which developed patient capability for managing their condition in the long-term. In other words, *how* we educate matters. I would also add that we need to avoid falling into the trap of thinking that education alone is sufficient to support engagement. We lose sight of this all too often. A PhD student of mine has talked about the importance of an 'educational experience' (see <http://aut.researchgateway.ac.nz/handle/10292/11773>). While her research was set in a different context and population, I think this framing helps to shift how we think about patient education and its role and function in rehabilitation.

Reference: *Disabil Rehabil.* 2018 Nov 14:1-13. [Epub ahead of print]

[Abstract](#)

6TH ASIA-OCEANIAN CONFERENCE OF PHYSICAL AND REHABILITATION MEDICINE, AUCKLAND, 21-24 NOVEMBER 2018

I was fortunate to attend the 6th Asia-Oceanian Conference of Physical and Rehabilitation Medicine, combined with the Rehabilitation Medicine Society of Australia and New Zealand's 3rd Annual Scientific Meeting. The conference theme was the "State of Art of Rehabilitation Medicine: North to South, East to West". This interdisciplinary conference attracts physicians, surgeons, allied health professionals, speech language therapists, dietitians, social workers, rehabilitation network managers and coordinators, clinical psychologists, researchers, registrars, university lecturers, staff and students, who combine to share knowledge and contribute to rehabilitation medicine. I have selected five of the invited speaker sessions to share with you.

Long-term functional outcome after acquired brain injury

Speaker: Professor John Olver, Consultant Physician in Rehabilitation Medicine and Professor in Rehabilitation Medicine in the Department of Medicine at Monash University. He is Medical Director of Rehabilitation at Epworth Healthcare, Melbourne, Australia, where he is also Coordinator of the Epworth Rehabilitation Acquired Brain Injury Programme.

Summary: Professor Olver discussed the ongoing symptoms that compromise the functional recovery and quality of life of people who experience an acquired brain injury (ABI). He described how shifting the focus of post-ABI review towards the ongoing surveillance of symptom trajectories has improved the management of specific injuries within designated diagnostic and treatment clinics. He talked about recent ABI research initiatives undertaken by him and his team, which include olfactory impairment in TBI, the establishment of an olfactory impairment clinic and the creation of a programme to treat ongoing post-concussion symptoms affecting physical, cognitive, sleep and emotional aspects of a patient's life. Early evidence indicates that these initiatives are successfully reducing the severity of symptoms and helping to increase patient activity.

Comment: Prof Olver offered insights into a range of work being undertaken at Epworth Healthcare in ABI. It was particularly interesting to hear about their research exploring the impact of olfactory impairment following TBI (see [this paper](#)). They have found that loss of sense of smell can have significant impact across a range of spheres of life including on personal safety (e.g. inability to detect gas), loss of enjoyment in social situations leading to withdrawal, a limiting factor on job selection, difficulty monitoring hygiene, and so on. Their research has found that up to 66% of people with TBI experience olfactory impairment, with only a quarter of those returning to 'normal' at 6 months. This is a good reminder of the significant and wide-ranging impact that a single symptom can have on someone's sense of self and well-being – something I think we too often take for granted.

[Abstract](#)

"It's not only the injury but also the kind of head that matters": factors predicting cognitive and psychosocial outcome following traumatic brain injury

Speaker: Professor Jennie Ponsford, Professor of Neuropsychology and Director of Clinical Programs in the School of Psychological Sciences at Monash University and Director of the Monash-Epworth Rehabilitation Research Centre at Epworth Hospital in Melbourne.

Summary: This presentation discussed findings from investigations into how physical, cognitive, behavioural and emotional factors influence post-TBI functional independence, work, study, social and leisure activities and relationships. One study sought to characterise how the notion of resilience fits with demographic, injury-related, cognitive, emotional and family factors and how all of these factors affected participation in 245 people with mild-severe TBI (mean post-traumatic amnesia [PTA] 24.95 days), who had sustained a TBI on average 4.63 years prior to study entry. At baseline, all participants completed the Participation Assessment with Recombined Tools-Objective (PARTO-17), Traumatic Brain Injury Quality of Life Resilience scale, Family Assessment Device General Functioning Scale, Rey Auditory Verbal Learning Test, National Adult Reading Test, and the Hospital Anxiety and Depression Scale (HADS). In multiple regression analyses, higher participation was associated with shorter PTA duration and more years since injury, as well as higher education and IQ, younger age and greater resilience. The relationship between resilience and participation was mediated by the severity of depression (determined by the HADS score), indicating that lower levels of resilience are more likely to lead to depression, which in turn is associated with poorer participation and psychosocial adjustment. Findings from a second study emphasise the importance of cognitive reserve for recovery of cognitive function after TBI: it found that although PTA duration, age and IQ all play key roles in the initial degree of cognitive impairment, the extent to which people recover cognitive function over time is associated with IQ and to a lesser extent age, not with injury severity. Lastly, Professor Ponsford described the results of research undertaken in her research unit demonstrating how people from a culturally and linguistically diverse background are less functionally independent and more emotionally distressed than Australians matched by demographic and injury severity variables. According to her work, cultural background plays a key role in predicting outcome.

Comment: Professor Ponsford argued that while there is a growth in the use of multivariate approaches to develop predictive models of outcome following TBI, to date, these account for only 30% of variance in outcome. This means there remains a number of unidentified factors that may contribute to outcome in this population. She spoke about a number of ongoing projects that aim to address this gap. The work that most took my interest was that which focused on resilience. Resilience was found to be a predictor of outcome as long as 13 years after injury! Professor Ponsford therefore argued for the development of screening tools and interventions targeted at strengthening resilience. There are two things I would add to this: 1) We may want to consider the fact that our TBI population is made up of some of our most vulnerable and marginalised communities. We therefore need to consider what the cumulative impact on resilience might be for those people; 2) If you are interested in exploring this further, I encourage you to take a look at Prof Angie Hart's (University of Brighton) work on resilient communities. Her work really challenges individualistic notions of resilience, which may help us to consider how we can create the context for resilience in our rehabilitation settings.

[Abstract](#)

PREP2: tailoring upper limb rehabilitation after stroke

Speaker: Associate Professor Cathy Stinear, Associate Professor in the Department of Medicine at the University of Auckland.

Summary: This presentation described the development of the PREP2 algorithm and its application for patients with new upper limb weakness post-stroke, previous stroke, haemorrhagic stroke, thrombolysis and thrombectomy. Research by Associate Professor Stinear and colleagues has shown that PREP2 is an efficient, accurate and accessible tool for clinicians to use when wanting to make predictions on upper limb outcomes in individual patients with stroke. The following benefits are associated with PREP2: it is more accurate than clinical judgement and improves clinician confidence; guides individual tailoring of rehabilitation and improves rehabilitation efficiency; and reduces length of hospital stay. Moreover, PREP2 can stratify patients in clinical trials of upper limb rehabilitation after stroke.

Comment: How do you respond to the question 'Will my hand get better?'. Questions like this are common following stroke and our lack of ability to offer a clear prognosis frequently leaves both patients and health professionals feeling frustrated and powerless. A/Prof Stinear argues that in fact practitioners are inordinately bad at predicting motor recovery following stroke, at least in part because it is not uncommon for two people with the same clinical presentation to have markedly different outcomes. This has led to more than ten years of research for A/Prof Stinear and her team and ultimately the development of PREP2, an algorithm for predicting upper limb outcomes for people following stroke. There is growing interest in the role of predictive tools, and similar stratification tools, to support a more tailored approach and to improve efficiency in rehabilitation. PREP2 has received widespread interest, both locally and internationally. Indeed, it is a knowledge mobilisation success story with it now embedded into routine practice at Auckland City Hospital and soon to be taken up by others. Like anything, there are some possible unintended consequences with a tool like this. For example, what are the implications of a poor prognosis for someone, and how is that experienced by patients and practitioners? Questions like this need further exploration. Regardless, it is clear that how this tool is used matters greatly. A/Prof Stinear and her team are well aware of this and are already drawing on research in oncology for guidance on delivering life-altering information to support capability-building for practitioners who are responsible for communicating prognosis. Watch this space!

[Abstract](#)

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Musculoskeletal medicine, treatment and rehabilitation for pain disorder

Speaker: Dr John Alchin, Physician based at the Pain Management Centre at Burwood Hospital, Christchurch, New Zealand, and Clinical Senior Lecturer in the Department of Orthopaedic Surgery and Musculoskeletal Medicine, University of Otago, Christchurch. He is also the current President of the New Zealand Pain Society.

Summary: Pharmacotherapy has minimal to no efficacy in several pain conditions, including acute postoperative pain, acute migraine, chronic musculoskeletal pain, and neuropathic pain. Among the 10–15% of patients who do respond to analgesics, reported associated benefits include improvements in fatigue, depression and sleep, as well as general measures of function and quality of life, including the ability to work. For adults with neuropathic pain, strong evidence supports use of first-line noradrenergic antidepressants (tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors) and gabapentinoid anticonvulsants, whereas the evidence is weak for the use of tramadol, capsaicin, and lignocaine, all 3 of which have been demoted from first- to second-line therapy. Weak evidence for the use of strong opioids (i.e. with maximum effectiveness at 180 mg morphine equivalent) and subcutaneous botulinum A has demoted these medications to third-line use. Moreover, opioids are associated with tolerance and physiological dependence, opioid use disorder, opioid-induced hyperalgesia, withdrawal problems and risk of accidental overdose. The evidence contradicts use of cannabinoids and valproate in neuropathic pain, strongly contraindicates the use of levetiracetam or mexiletine, and fails to support combination therapies (e.g. a tricyclic antidepressant or serotonin-norepinephrine reuptake inhibitor + a gabapentinoid; an opioid + morphine + gabapentin or nortriptyline). Evidence is weak for the efficacy of cannabinoids in neuropathic pain and limited for use in chronic non-cancer pain. Besides, cannabinoids have adverse effects.

Comment: This was the most interesting talk on pharmacotherapy I have ever been to! The tricky thing, however, was that the overriding message was that pharmacotherapy inherently fails to manage pain well. Dr Alchin drew on [Moore et al.'s 2013 BMJ paper](#) "Expect analgesic failure; pursue analgesic success" to argue: a) for a personalised approach to prescribing with a focus on seeking out *responders* (a minority) versus *non-responders* (the majority); b) that oftentimes the focus is (and should be) on withdrawing medications that are not working; and c) given the limited impact of pharmacotherapy, the need to work within an interdisciplinary team. Indeed, he made the pertinent comment that the *bio-psycho-social model* could indeed be the *social-psycho-biological model* – a useful shift to denote where the emphasis needs to be to most effectively manage pain-related disability. This is of course not a new message. However, we still frequently fail to miss the mark on this in practice. The biomedical paradigm remains as strong as ever. Ask yourself – what will it take for you to shift the emphasis in your own practice setting?

[Abstract](#)

Improving the timeliness and effectiveness of rehabilitation of individuals with chronic musculoskeletal pain

Speaker: Professor Rob Smeets, Consultant in Rehabilitation Medicine at Libra Rehabilitation and Audiology and Professor at Maastricht University, The Netherlands.

Summary: This presentation highlighted the challenges faced by clinicians when treating patients with chronic pain, many of whom experience pain-associated disability and a lower quality of life. Professor Smeets discussed the important role of nonmedical factors, including a biopsychosocial approach, in the rehabilitation of patients with chronic musculoskeletal pain. He described ways in which clinicians can usefully inform patients about their pain, improved methods of treatment and how to help them remain active despite ongoing pain.

Comment: The message in this presentation was consistent with the general tenet of Dr John Alchin's presentation – we need to move away from the dominant biomedical model which is "mono-disciplinary" and where the primary goal is pain reduction. Professor Rob Smeets argued that the biomedical model does not sufficiently explain pain – MRI findings have a poor relationship to outcome and to treatment effectiveness. His strong advice was that we need to start telling clients that we are not good at treating pain, but that we can help them to live life in the context of their pain. With this in mind, our treatment focus should be, not on the pain itself, but on factors that help pain-related problems to persist. Professor Smeets drew attention to a number of projects targeting social and psychological factors. One particular approach that caught my attention was the development of personalised fear avoidance models as a tool for providing personalised explanations about pain to clients. While I am sure many practitioners talk about how the fear avoidance model might more generally apply to clients – taking the time to construct a more personalised model may help clients to relate that to their own experiences. This could potentially be a powerful tool.

[Abstract](#)





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www.livestronger.org.nz website is full of advice, information and resources for older

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