SPORTS PSYCHOLOGY TO REHABILITATION MEDICINE: A CONVERSATION WITH SHELLEY WIECHMAN

Shelley Wiechman, PhD, is the attending psychologist at the University of Washington's Regional Burn Centre, Pediatric Trauma Centre, and the Pediatric Clinic at Harborview Medical Centre. Wiechman is an expert in adjustment to injury or disability, non-pharmacological pain management, and paediatric mental health and is a strong advocate for creating active partnerships with patients to reach the best possible outcomes. Her research interests include the use of hypnosis for pain and itch and long-term adjustment to burn injury.

Wiechman sat down with Lincoln Tracy, a research fellow from Monash University, Australia, at the 43rd Annual Scientific Meeting of the Australian and New Zealand Burns Association Annual Scientific Meeting, which took place on October 15-18, 2019, in Hobart, Australia. They discussed Wiechman's journey to working in rehabilitation medicine and psychology, how getting to form relationships with patients helps combat burnout, and more. Below is an edited transcript of their conversation.

What was your path to rehabilitation medicine and psychology?

I was an athlete and a huge fan of sports growing up. However, since I didn't have a lot of natural talent, I needed to rely more on my mental skills and toughness to succeed. I did my initial training and started out as a sports psychologist. This involved a lot of work with athletes helping them to use their mind to achieve a peak performance and find their optimum zone of functioning.

When I was in grad school, I did a practicum on the burn and rehab units. As part of the practicum I spent a lot of time working with people undergoing painful rehab for burns, learning to walk again after a stroke, or learning how to change their direction in life after a devastating spinal cord injury. During my time there I realised that was a peak performance for them and realised that the skills I had been using with the elite athletes, who were very mentally tough, were the same skills that could benefit patients who needed to get their life back again.

A key part of that meant performing through the pain. Elite athletes play through pain all the time, because they learn that pain doesn't always mean harm. We were seeing the exact same thing on the burns unit—that patients were experiencing a lot of pain that didn't necessarily mean harm. It was a great opportunity to think about what non-pharmacological techniques we could use to help a person achieve their goals despite the pain, such as getting through painful physical therapy or occupational therapy sessions. That's where my two worlds really merged.

After that practicum I realised that working in the burns and rehabilitation space was where my passion was and that I wanted to work with people with devastating injuries to help them get their life back. I was lucky that there was a job opening in this area at the place I'd done my training, so I could move right into it and start using the sports psychology skills in rehabilitation. My dissertation involved working with patients with trauma pain, and that flowed nicely into the clinical work I was doing in the rehab space.

How did you make the transition from clinical work into research?

During my sports science days I had worked with elite athletes who had gotten injured and spent a lot of time working through their pain issues as part of their rehabilitation. Then my dissertation investigated the use of patient-controlled analgesia in the population of trauma patients that had a history of drug and alcohol problems and whether these pre-morbid risk factors influenced opiate use. I found that when you take someone with an alcohol and drug problem, and you give them control over their management with patient-controlled analgesia, they use either just as much or even slightly less [patient-controlled analgesia] than somebody without an alcohol and drug problem.

When I started on the burn unit, I was seeing that pain seemed to be the barrier to achieving the patients' desired quality of life. Pain was impacting their mood, their sleep, or their ability to function. It was preventing them from fully engaging in their intensive physical therapy programs, or the acute pain during wound care procedures was so traumatising that they went on to develop PTSD.

So, given my history in working with elite athletes, my dissertation work, and the fact that my mentor, Dave Patterson, was really involved in acute pain management, it was a natural fit for me to follow in his footsteps. I thought, "We've got to find better management for acute pain. [So] let's continue to look at hypnosis. Let's look at distraction—whether that's through virtual reality or mindfulness. What is it that we need to do to help these people manage pain so they can participate in their own rehab?"

How does your role fit into the multidisciplinary nature of the burn unit over in Seattle?

I'm very fortunate to work on a burns team that has a longstanding tradition of supporting psychologists. The previous directors really embraced the role of psychology and while they have moved on, the rest of the multidisciplinary team is very welcoming of psychologists and very much understand the importance of mental health. We're very well resourced, with surgeons, intensivists, physicians, a pharmacist, a chaplain, social work… the list goes on. We all round together twice a week to make sure that the patient's needs are met from each discipline's point of view.

Another thing that I have benefited from is that I meet patients when they first arrive in the ICU, follow them through their acute phase of hospitalisation, and then see them when they come back for appointments in our outpatient clinic or another rehabilitation setting for years afterwards. The opportunity to have continuity of care and develop relationships with our patients is something that is very valuable to me. We tell them, "You're part of the burn family, and so you can always come back. You have a place to come to."

It's been particularly fun getting to work with the kids. I'll get to meet them in our burn unit, and then get to reconnect with them when I go out to our camp that we

have for kids with burn injuries. A lot of the kids that we started working with at age five have now grown up, gotten married and had their own children, and now come back to the camp each year as counsellors. It really helps me combat any burnout or compassion fatigue. Getting to see how successful these people, who experienced an incredibly traumatic situation when they were young, have become really helps me understand and experience the resiliency of the human spirit. The light at the end of the tunnel is very positive.

This week you have spoken about the importance of recognising the difference between procedural pain and anxiety. Can you elaborate on why this is important, and how you assess the difference between the two?

Differentiating between pain and anxiety is important because we know that anxiety exacerbates your experience of pain. When we assess someone and they're off the charts in terms of pain you've also got to look at how much of a role anxiety is playing in that. It's also important because pain and anxiety can require different treatments. Luckily, a lot of the techniques target both pain and anxiety, but you really need to know what you are dealing with. We don't want to treat anxiety with an opioid, and we don't want to treat pain with an intervention that only targets anxiety.

Your assessment of pain versus anxiety must be brief, as it is something you need to do at the bedside and often on multiple occasions. We find that when parents bring their children in, they have a really good idea of their child's coping style—they've just never used that kind of language before. So, when you are taking their history on intake you ask, "How does your child respond to medical procedures? How do they respond when they get an immunization? How do they respond when they have a skinned knee?" You can ask adults the same kinds of questions: "When you've been injured in the past, are you an approach coper or an avoidance coper?"

The main thing to remember is that the assessment is a quick couple of questions that allow you to figure it out and assess as you go. Asking questions like "Is virtual reality still working for you during wound care, or are you feeling like it's actually creating anxiety because now you want to participate in wound care?"

And finishing on a more light-hearted note, if you could have a dinner party with anyone—dead or alive—who would you want at the table with you and why?

I tend to be really intrigued by people who have reached peak performance in their field, particularly if they have pure raw talent and have overcome adversity to succeed. A lot of the time you see people who that are talented but are unable to come back after a major downfall. One of those people who I'm incredibly interested is Neil Armstrong. How do you have that much courage to be the first man in space? That is a peak performance in real life, and I think it's incredible to be able to remain calm under that kind of pressure.

Michelle Obama is my current idol, I love how she presents herself. I love how she can be in a supportive role to a very powerful man but then also make a name for herself. I love her causes, values, and demeanour. I think she'd be fascinating to talk to. And Eleanor Roosevelt is similar, I think she was very understated yet had the confidence to do great things without needing to be in the limelight.

I've got to have one elite athlete there, so I have to go with Michael Jordan. I respect the fact he was able to maintain his athletic prowess for so long. He clearly had pure raw talent, but he also had a mental toughness. I'd also be

interested in meeting one of the survivors of the Boston Marathon bombing. There have been a lot of life-changing stories about them. I think it would be interesting to bring someone to the table who has experienced a tragic, life-changing event, and has managed to turn around and get their life back together.

Lincoln Tracy is a researcher and freelance writer based in Melbourne, Australia. He is a member of both the Australian Pain Society and the Australian and New Zealand Burns Association. You can find him on Twitter @lincolntracy.

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• Trainee/early career researchers (i.e., researchers currently undertaking their PhD, or within five years of PhD conferral) to visit a major metropolitan multidisciplinary pain centre for the purpose of conducting/initiating a clinically-oriented research project that involves the development of a new partnership/collaboration with allied health, nursing or medical pain specialists. Projects can use basic science or applied methods, but the clinical relevance of the project must be clearly articulated.

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