



Airing Pain 147: Person-Centred Care

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Edition features:

Vicky Sandy-Davis, Lead Nurse for Independent Health and Social Care, West Midlands

Ian Taverner, Chair of the Public Advisory Group of CRIISP (Consortium to Research Individual, Interpersonal and Social Influences in Pain)

Sarah Harrisson Research Associate in Applied Health Research at Keele University, Specialist Pain Physiotherapist with the IMPACT Community Pain Service (Midlands Partnership NHS Foundation Trust) in Stoke-on-Trent

Professor Nicole Tang, Director of the Warwick Sleep and Pain Laboratory, Academic Co-Lead for the Warwick Health Global Research Priority Mental Health Theme

Jenna Gillett, PhD student at Warwick University and Lecturer in Psychology at the University of Buckingham.

The edition is presented and produced by Paul Evans. The interviews were recorded at the British Pain Society's Annual Scientific Meeting, 2024.

Transcript begins

Paul Evans: This is *Airing Pain*, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, our family and supporters and the health professionals who care for us. All the interviews for this edition of *Airing Pain* were recorded at the 2024 annual scientific meeting of the British Pain Society at Nottingham University. Each year it's a major platform for pain management



professionals, researchers, clinicians and industry leaders to come together to exchange insights and explore the latest developments in the field of pain. And we're grateful to the British Pain Society for their support in providing facilities for us to record at these events. I'm Paul Evans.

Nicole Tang: When an animal is being attacked, at which point they would declare defeat by showing the defeat behaviour, like head stooping down and showing, you know, signs of okay, now I've been defeated, stop the attack – some would just say “okay, I am giving up!” after, let's say, ten bites. And some would not stop fighting back until, you know, they have been bitten a hundred times.

Ian Taverner: When you're living with pain to be asked by a researcher is quite a novel thing, but it's so important. I think the session we had today just proved that; how important it can be and how it can change the trajectory and the direction of your research just by having people within it right from the beginning who live with pain.

Evans: We are all different. I know, not earth-shattering news, but is it too convenient to lump individuals together under banners that suit researchers and healthcare professionals whilst ignoring the unique makeup of an individual? Here's an example: a person living with chronic pain has a learning or intellectual disability. They're also in the criminal justice system. That's three boxes to tick: learning disability, prison and pain.

How do these three interact with each other? Person-centred care – that is, a care plan or treatment based on the individual rather than on a generic group of patients – has been gaining traction for some years and in the meeting the term cropped up in several presentations. In one of them, Vicky Sandy-Davis, who is a qualified learning disability nurse, spoke about person-centred assessment of people with intellectual or learning disabilities.

Vicky Sandy-Davis: The definition of learning disabilities has changed over the years. It used to be that we'd look at somebody's IQ and if it was below



70 they would have. If it was between about 60 and 70 they would have a mild learning disability and then there were different stages of learning disability going down to profound learning disability, which is someone with an IQ of around 20, 10 to 20. Now, a learning disability, in terms of definition, we look at somebody's comprehension skills, somebody's social skills, everyday living skills... all of those things together will mean that somebody may have a learning disability and might need support. A much higher proportion have healthcare needs compared to the rest of the population. There can be behavioural issues, there can be issues with accessing healthcare and accessing generic services. Education ... they might have problems getting employment for example, because I think about 7% of people with LD are in employment, and that employment might not be meaningful. So really a learning disability nurse will support a person with a learning disability in every area of their life. It's a really holistic way to support somebody and it's about empowering them and helping them to live independently.

Evans: Ok, we're speaking at the British Pain Society Annual Scientific Meeting 2024. What are you speaking to the delegates about?

Sandy-Davis: I've been speaking to them about diagnostic overshadowing which is about misattributing a presentation. So, for example if somebody with a learning disability can't communicate verbally and their behaviour changes, quite often that's attributed to their learning disability when actually it could be that person communicating that they're in pain. So diagnostic overshadowing is one of the things that I've spoken about. But also person-centred assessment, which is really important in terms of pain assessment. So, it's about getting to know the person, working out how they communicate and how you can identify that they're in pain.

Evans: So diagnostic overshadowing, I mean, that means that if I have a learning disability and I do something out of character, this, that, the other,



because I'm in pain, somebody might think that's because of my learning disability and not because I'm in pain?

Sandy-Davis: Yes. So, the scenario that I've used today is a person on a low-secure unit – because that's my area of practice, really – whose behaviour changed. And it's based very loosely on someone from my distant past, so not really identifiable at all. Somebody whose behaviour changed, and he was punching himself in the face and that resulted in him being restrained on several occasions, on his psychotropic medication being increased. So, in learning disabilities it's been found that something like 30 to 50,000 people have been prescribed psychotropic medication with no clinical indication that they need it. And when someone's behaviour changes for whatever reason, it's often assumed that it's because of their learning disability or because of an accompanying mental health problem and their psychotropic medication will be increased. So, something like antipsychotics for example will be increased. So, the problem is not tackled, the behaviour continues and they suffer the outcome. And that's what happens with diagnostic overshadowing.

Evans: People with chronic pain have invisible conditions.

Sandy-Davis: Absolutely.

Evans: How you get that understanding over can be really, really, difficult, especially when there's a learning disability involved.

Sandy-Davis: Exactly. If you consider for example someone with autism who also has a learning disability, they might respond to pain in a completely different way to everybody else. And trying to work out what it is that they're responding to can be incredibly difficult, and unless you get to know that person *really well* you're not going to be able to ascertain what's causing that behaviour change. And that's why it's so important that we get to know the person that we're working with, get to know the subtleties and nuances, in order to be able to ascertain how their behaviour's changed,



what their behaviour would look like in an everyday situation. I think the first question that I also ask is whether we really need that behaviour to change, is it causing anyone any problems? Is it because we don't find it tasteful? Does it not meet our societal norms? Do we really need to change that behaviour? Is it threatening in any way? And then, is this person trying to communicate something that needs to be dealt with?

My interest actually, over the years, has been in forensic learning disability. So, I work mainly with offenders with learning disability or intellectual disability, from the modern term. When I did work in practice as a forensic community charge nurse people would be referred to me by various means; they might have come through the police, they might have come through the courts, they might have come through families or other professional settings. The main aim of my role really was to keep *them* safe in the community and keep people in the community safe. And a lot of the stuff that I did was around monitoring them, making sure that legislation was being implemented correctly. Supporting them holistically as well, so if there's any healthcare needs or anything like that, I would be there to support them. Since I worked as a community charge and a forensic community nurse I've actually worked in education for 13 years and then came into the Royal College of Nursing. But my interest has always been in working with offenders with learning disabilities and mental disorder.

Evans: Why is that important to you?

Sandy-Davis: There's been lots of research around offenders with learning disabilities that come into contact with the criminal justice system. Prisoners with learning disability... the statistics change from around 20% of prisoners have a learning disability – and that can go up to 70% – but because learning disabilities aren't effectively identified in the prison service, in the criminal justice system, you find that a lot of people are overlooked. So, there are a lot of people with learning disabilities that come into contact, they're very vulnerable, they don't get the support that they need.



And then there's the important aspect of miscarriages of justice. So, someone with a learning disability might not understand the process of the criminal justice system, they can be prone to suggestibility, so if they're not interviewed in the right way, for example by the police, then they can admit to things that they don't really understand. That can be passed all the way through the criminal justice system and then they can be incarcerated for something that they haven't necessarily done. That's not *always* the case; people with learning disabilities can be guilty of all sorts of crimes, but they're very vulnerable in those kinds of situations.

Evans: That's really interesting, that the learning disability is not identified at the start of a legal process.

Sandy-Davis: Absolutely. Yeah. It's a big problem and it's an ongoing problem. So, until the police receive really good effective training in identifying people with learning disabilities or get the right support from health services or learning disability specialists they're not going to be able to identify people. And the really tragic thing in a way is that if a learning disability isn't identified at that first point of contact with the police, that will go with them all the way through the criminal justice system.

But one of the main ways to identify someone at the moment is from their previous record. So, if they've lived in residential care, for example, or they've received support from healthcare services that's one of the only ways to identify someone. But of course, not everyone with a learning disability has lived in those environments or has that kind of support. So yeah, there's some incredibly vulnerable people in the criminal justice system.

Evans: But you're not working within the legal system, you're working within the healthcare system.

Sandy-Davis: Yeah, absolutely, yeah. There are different professionals that are employed in healthcare settings that are working in partnership, I



suppose, with criminal justice. So, for example there are liaison and diversion nurses that will identify people with learning disabilities and then divert them to the healthcare system. A lot of the healthcare that's delivered in the prisons is run through private healthcare services or through the NHS. So, there are different roles for nurses in the criminal justice system and learning disability nurses especially. I mean, there have been a few pilots of learning disability nurses and mental health nurses, for example, going out on the beat with police to identify people in the community that might present with learning disability or mental ill health.

Evans: But you're a nurse, what's the medical side of this?

Sandy-Davis: Well – and that's the big question, because a learning disability isn't an illness, and it can't be treated. So, learning disability nurses – although they're trained in clinical procedures, I suppose, the same as an adult nurse and trained in dealing with healthcare problems, that's the nursing aspect – but actually a learning disability nurse looks after all sorts of other things as well. So, some people say it's a misnomer because we're more of a specialist I suppose than a nurse. But we do have that clinical aspect.

Evans: Because people are more than a health condition.

Sandy-Davis: Exactly.

Evans: Person-centred help is what they need.

Sandy-Davis: Of course, yeah absolutely. And you can't really implement a person-centred approach without getting to know the whole person and that's what learning disability nurses are really good at, I think.

Evans: We've just been through two years of COVID.

Sandy-Davis: Yeah.

Evans: I mean, how has that affected your area of work?



Sandy-Davis: People with learning disabilities during COVID were at a *huge* disadvantage for lots of different reasons. The mortality rate was twelve times higher in people with learning disabilities. There was some really questionable practice: for example, care homes were given blanket DNR orders. So whole care homes full of people with learning disabilities were told that they didn't need to resuscitate them because they had a learning disability. And it doesn't get much more unfair than that. That was a big problem in COVID. I worked with people who weren't given the right treatments. For example, a lady who was put at the bottom of the list for a respirator, even though she had respiratory problems *because* of COVID, who later died – passed away – because of COVID. She wasn't given the right treatments.

So COVID really brought out the inequalities in the way that people with learning disabilities are treated in our healthcare system. And there are other examples, things like the Francis report that resulted in deaths of people – avoidable deaths of people – with learning disabilities. The list goes on and on. And until people start to really recognize the *value* that someone with a learning disability has and the fact that they can contribute as much to the community as the next person, that's always going to be the case.

Evans: Disability is not an inability to do something. It's *society's* inability to allow that person to function.

Sandy-Davis: Absolutely. And that sums up the role of a learning disability nurse to overcome that problem.

Evans: That was learning disability nurse Vicky Sandy-Davis. While still focusing on the individual rather than on a generic group, in this case, all people with chronic pain, are the first hand, the lived experiences of those of us living with chronic pain adequately represented by researchers and healthcare professionals. “Beyond tokenism: Working with patients and public contributors in pain research” was another seminar at the British Pain Society Annual Scientific Meeting. Two of those presenting the session were



Ian Taverner, who has chronic pain and chairs the public advisory group of CRIISP. That's the Consortium to Research Individual Interpersonal and Social Influences in Pain. And Sarah Harrisson, who's a clinical academic at Keele University and a physiotherapist in the community pain service in North Staffordshire.

Sarah Harrisson: People who I know through my clinical experience, the people living with chronic high impact pain, find it really hard to engage in the things that matter. Their pain causes a lot of distress. They have a lot of disability. Asking them to take part in public involvement work or other research related activities is almost impossible. But actually, it's really important because they are underrepresented in public involvement and in research. So, actually, the research that we do have doesn't represent them. It represents people with *less* pain and *less* disability. So, what we need to do is we need to involve those people at that time when they *have* severe pain and disability and find different ways of doing that, that's acceptable, that's meaningful, that's relevant to them. And I think by doing that what we hope is actually the future research will also be relevant and acceptable to this group who have really severe pain.

Evans: I was involved with research in Warwick University and as a professional, as I'm doing now talking to you and making these podcasts for *Airing Pain*, I also took part as a subject. It's a completely different feeling! I find it really good, being able to talk about things that actually I haven't said to other people beyond my family.

Harrisson: Yeah, and I think that's what we've found just from today but also in some of the work that we've been doing. But actually involving yourselves in public involvement in research, helps people develop the way they self-manage their own pain conditions because they learn from other people, that actually there *is* no "best clinician" or there is no "new way" or "magic pill". That helps them on that journey of living with pain, which is really difficult isn't it?



Evans: Ian, have you been involved as a subject in research?

Taverner: No, I haven't. So being involved in CRIISP was the first time I've done anything like this before. But it came about because when my life changed with what happened with my illnesses, I ended up at the Pain Centre in Bath, on a four-week programme there and then one of the people there contacted me and said, "CRIISP are looking for someone to be in the public advice, I think you'd be good for it." So, I applied, thinking I don't know where this will go, but then I got the job, and then it really sparked this whole public involvement work for me. And with my other role that I do with helping people around cooking, they do cross a lot, because the more you listen to people and share and understand the different types of pain that people live with and how it... because I know how it works with me, but I don't know how it works with *other* people. So, once you start to get that it broadens your knowledge so much and therefore seeing how that goes into research –it's obvious but not obvious, if that makes sense?

Evans: What always surprises me coming to these things, is actually I hear so much common sense spoken by you lot and everybody else. Are you talking to the converted?

[Harrison and Taverner laugh]

Harrison: It makes sense doesn't it, we do this for patients it makes sense to involve them in the research. But... it's not widespread through research, but it *is* becoming more important. And we really wanted it to be visible at the conference, which is why we organised this workshop.

Taverner: A lot of people will say, yes, we do use public contributors, but *how* they're being used is really variable. So, what we were talking about today was very much about really investing in them and putting people at the centre of this rather than the periphery.

Evans: Absolutely. It's one thing to take part in a research programme, but not to be used as a statistic. Keep feeding back to us what the research has



done, what the results are, how you've helped. I think that's *ever* so important.

Taverner: It's not good enough to say, "this is what we've done." It's right, isn't it? The people who are living with pain should be involved in the process to *get* to that point, not at the end of it, and that's the big shift that it's hard to make.

Evans: Ian Taverner. Well, the research programme for which I was a subject is the University of Warwick Study of Mental Defeat in Chronic Pain. You can hear all about that in *Airing Pain* Edition 134, available from the Pain Concern website, which is painconcern.org.uk. The study's now at the point where the data collected, including mine, is being analysed. I caught up with the study's lead, Nicole Tang, who's director of the Warwick Sleep and Pain Laboratory, and Jenna Gillett, who's a PhD student at Warwick and lecturer at the University of Buckingham. Let's just remind ourselves of what mental defeat is. Nicole Tang.

Nicole Tang: Mental defeat is a cognitive construct that we are trying to apply to understand the psychological experience of so many patients with chronic pain sometimes have. Essentially, it's a concept that helps us to see and feel, to understand the impacts of the daily assault of chronic pain on a person's sense of self and identity. So, I have spoken to many, many patients with experience, how they struggle with getting on with their life. Sometimes they feel like the pain has really taken over, that the pain has taken *away* the identity of who they are. They can't do the things that they used to be able to do. They can't do things right in front of them. And at that point when they're struggling with pain, they can't really see through pain into the future.

So, I think it is a concept that helps us to understand how a person interprets their own situation in relation to the pain. And it just sort of gives us a window to understand that psychological experience. It is a concept that has been studied in other areas of psychopathology, including



depression, post-traumatic stress disorder, and psychosis, and particularly in the area of suicide. So, there are lots of major theories of suicidal thoughts and behaviours that have used the concept of mental defeat to try to understand how our thoughts and interpretation of a situation, and how yourself relates to the *wider* context, could help us predict suicide risk. And so that is the concept that we're trying to employ to understand particularly those people who are feeling a high level of distress when they are struggling with chronic pain.

Evans: Well defeat signifies that it's a battle lost. Having chronic pain is a grind, I know that. I've never really thought of it as a *battle*, something to fight against. It's more accepting that it's there and it will be there. But at what point does that daily grind, yearly grind, the battle, if you like, turn into defeat?

Tang: Yeah, that's a great question. I mean it is a highly personal question, I would say, because from the animal research where they use social defeat as a model to understand, you know, when an animal is being attacked, at which point they would declare defeat by showing the defeat behaviour – like head stooping down and showing signs of, “okay, now I've been defeated, stop the attack” by the attacking animal. So, it highly depends on the animal [laughs]. Some would just say, “okay, I am giving up” after, let's say, 10 bites, and some would not stop fighting back until they have been bitten a hundred times. So, it depends. And I think a lot of different factors would determine how a person would feel at any single point. But for people with chronic pain, the daily grind really takes a toll on them, and they are particularly vulnerable to be, you know, feeling defeated by the pain when they can't do the things that they want to do, when they can't become the person they want to be in the first place.

Evans: That's a particularly graphic image, especially for those of us who watch the natural history programmes. When you see the point when the



chased animal, the meal, if you like, gives up, rolls over, and that is it. And putting that into human terms, Jenna, well, I don't know how to describe it.

Jenna Gillett: [laughs] It's quite difficult to describe, so you're not the only one. Yeah, we use the animal models of social defeat because obviously it is a very difficult thing to look at in people. And as Nicole said, there are so many different factors that would influence... if you have two people with the exact same chronic pain condition, they're still going to experience that condition very, very differently. And there's so many different psychological factors, biological factors, and social elements as well, that are all going to play into how one experiences their pain. Even within the same person, it will maybe be different across when you first – if you get a diagnosis – when you first experience that, compared to, maybe, two, five, ten, twenty, fifty years later. You know, there's always going to be this level of fluctuation and change. So, it is genuinely a very difficult thing to pinpoint and say, “this is exactly what mental defeat looks like in everybody”.

The important thing is to sort of look at the big picture of mental defeat. Whether you are a clinician and you're, you know, you're seeing patients all the time, whether you're someone living with chronic pain – a lot of people can relate to the experience, but people don't necessarily put together that that's mental defeat. So, it can look quite different in everybody. But one of the key elements to it is this *powerlessness* of it. So, it's about an attack on who you feel you are as a person because of the pain. So, your sense of self might be intertwined with, you know, your experiences of chronic pain and that – as you say – that daily grind, that yearly grind, the persistent-ness of it, that takes a toll on a lot of people.

Evans: So, I guess from one extreme, we could be just, “I've had enough, I'm giving up work. The things that keep me ticking over mentally, that's my lot”. It could well be giving up and saying, “I'm going to sit at home and stare at four walls.” And at the extreme, it could be suicidal thoughts.



Tang: Yeah. That's why we're trying to use the presence of defeat, mental defeat, to help us to understand that difference. Why some people may behave differently or just respond to chronic pain differently than the other one, who may be experiencing the same level of pain. You know, apparently similar pain intensity, similar pain situation, why one person will respond with a higher level of distress and disability and then the other person may be, "okay, yeah, I'll just get on by." But by understanding that difference, we can perhaps try and do something. Because, I mean, by saying that you feel defeated, there's nothing to be ashamed of. Because it's highly understandable, given that situation – if suddenly, you know, I have a lot of pain and that just won't go away, I will think the worst, I will be very worried and I will feel like, "oh, I'm *incapacitated*". So, this is highly understandable, it's nothing to be ashamed of.

But I think the important thing is to understand that that feeling of defeat can be changed. And so, we are looking into how to do intervention that could help people to get themselves from that deep hole that they feel there's *nothing* that they can do about the pain. There's *nothing* that they can do to improve the quality of life. So, we want to be able to help people change that.

Gillett: So, some of the work that we presented at this conference was looking at the risk factors for that one end of the spectrum where, you know, the people who we can identify that they have got particularly high, maybe, levels of mental defeat and then we're looking also at their levels of suicidal behaviour as well. So obviously this is a very at-risk group of people. So, one of the things we were looking at in the mental defeat study was those predictors of, okay, so what's going to be these markers, these risk factors for this group of people? And some of the risk factors that we found, for example, were around obviously like the depression levels as well... You know, I mean, it sounds, okay, yes, that's logical, that would make sense. But prior to this, there's not been much research looking specifically at, you know, the mental defeat in the chronic pain context and tracking that across



time. And then also there were some other risk factors as well. So, we looked at things initially over six months and then we repeated things again over twelve months to again see: *are* things staying the same? Are they slightly fluctuating? And yeah, we found that consistently with the risk factors for suicidal behaviour, it's your mental defeat scores that are coming out as relevant, and also those depression levels as well that we looked at across twelve months.

Evans: So, the research experiment that I took part in, suddenly living with chronic pain, was to try and work out what my attitudes were to pressure and pain?

Gillett: A lot of the time people do research by, you know, just doing survey, cross sectional. "What happened in one single time point?" We have also done that to try to understand the relationship at the superficial level. When you joined us as a participant, that was the time when we were doing *experiment* to see if we can activate the sense of mental defeat, and would that have a direct and immediate effect on people's pain responses? So, we've done some pain testing, get you to put your hands in a bucket of cold water to see your cold pain threshold, et cetera, et cetera, and also conditional pain modulation. So that was a fun experiment, but it's really, really hard to carry out those experiments. So, we've done that and we are still looking at the data, but we have collected more data by asking people to give us some in-the-moment rating of the sense of defeat, the mood, the functioning when they're at home, doing their own thing. So, we want to have that very realistic sense. What happened? You know, if you're feeling defeated a little bit, what will happen to your physical activity during the day, your use of medication, whether or not you're engaging in social activity and seeing friends, doing things that you want to do, et cetera, et cetera.

So, we're analysing those data in a more dynamic, temporal sense. And what we're seeing right now at the very preliminary [laughs] analysis level is



that the way how mental defeat works may be a little bit more indirect than direct. It will affect your mood, the way how you pay attention to things, but there seems to be a rather stable association with the level of functioning during the day in different contexts. So, we are quietly excited about that, but we can only say some more once we have completed the analysis and reported that. But I think it is operating in a way that would translate from, you know, just the thought of defeat to our actual behaviour.

And so that is largely aligned with the generic cognitive behavioural therapy model, the way how we interpret our situation, our psychological state could have an influence on our emotions, the way we feel, and also our behaviour, the way we respond to a situation.

Evans: To me, it would be fairly obvious that the results you would get from coming to the lab and being at home, day-to-day life would be completely different. I mean, after doing the stuff in the lab... *[Jenna and Evans laugh]* Firstly, I was very nervous. Secondly, you come away thinking, "did I give the correct answers?"

Gillett: Yeah, there are no correct answers.

Evans: "What did I say? Did I mean that?"

Gillett: *[laughs]* Yeah, there are definitely no right or wrong answers with these things. And that's why it took so long for us to do because we wanted to make sure we're capturing all these different ways of looking at mental defeat. So, in an artificial lab, highly controlled experimental setting, which was what you did when you came and joined us, that's one way of looking at it, where you can really pin down, OK, like you say, "can we activate this sense of mental defeat?" Because if, in theory, if we can activate it, then maybe down the line, we can look at how we *deactivate* it. And that would, you know, obviously help people that are going to experience defeat.

Tang: You are absolutely right. You know, there are trade-offs in an experimental setting.



Gillett: Yeah.

Tang: Although we have very good control of the confounding variables, but we also perhaps, you know, make you feel a little bit anxious and you are reacting to the situation *as well*. So, we understand that. But I have to say, Paul, you have done really well. [laughs] And I hope that our safety procedure... And I just want to have a shout out to all the participants who have come from further afield to come into the lab and really show an interest to what we are doing and help us out with doing the research. We are very appreciative of the time and effort.

Evans: It was an amazing experience. I'm a participant in lots more research projects, mostly online now, since doing that. Because it's such a worthwhile thing to do!

[Tang and Gillett laugh]

Evans: Honestly, there's going to be no progress in anything if people don't take part in research programmes. So, I did find that very good. And I was really well looked after. And I would do it again a hundred times over.

Tang: Aww, thank you Paul!

Gillett: Thank you!

Evans: And I would encourage anybody to get involved with these things. Somebody has to do these things for science to move on.

Gillett and Tang: Mm, yeah.

Evans: As in any research project, there's no point in doing it and then locking your findings in the bottom drawer. How do you put this across to – not just to people with pain – but the people who manage the pain, the physicians, the psychologists, the psychiatrists, the physios? How do you get that knowledge out there?



Tang: So, one common point that has come up from our discussion during the symposium is that we need to have a tool to help us assess and identify those patients with high level of mental defeat with suicide risk. And so we would like to make that questionnaire freely available so that more clinicians, if they're interested in the concept, they can just register and download the questionnaire. We will have information about the psychometric properties of the questionnaire freely available as references. So hopefully that will be a useful resource for the whole community.

Evans: That's Professor Nicole Tang. Just put the words Warwick Sleep and Pain Laboratory into your search engine to find out more about the Warwick Study of Mental Defeat in chronic pain. Now, if we've whetted your appetite for taking part in the study, those at the Warwick Sleep Lab are currently, that's in late 2024, recruiting volunteers to take part in the study into the relationship between pain and sleep and to investigate the feasibility of new approaches with a modified version of CBT. Go to the same website or email: sleppainstudy@warwick.ac.uk for more details.

And I'll remind you, as I do in every edition of *Airing Pain*, that whilst we in Pain Concern, believe the information and opinions on *Airing Pain* are accurate and sound, based on the best judgments available, you should always consult your health professionals on any matter relating to your health and well-being. They're the only people who know you and your circumstances and therefore the appropriate action to take on your behalf.

Now, it's important for us at Pain Concern to have your feedback on these podcasts, so that we know that what we're doing is relevant and useful and to know what we're doing well and maybe not so well. So do please leave your comments or ratings on whichever platform you're listening to this on or the Pain Concern website, of course, which is: painconcern.org.uk. That'll help us develop and plan future editions of *Airing Pain*. But to end this edition of *Airing Pain*, I leave you with Vicky Sandy-Davis on the importance of recognising the value of person-centred care.



Sandy-Davis: There is a much wider picture than somebody's behaviour. And people who don't communicate verbally, for example, will communicate through their behaviours quite often. And it's easy to react to those behaviours rather than proactively work with those behaviours. We tend to look at a person who behaves in a way that we don't find acceptable, doesn't meet our social norms. We try and change that behaviour instead of thinking about the reasons for that behaviour and changing the environment around the person. And that's the basis for positive behaviour support. So, we need to make sure that we're properly assessing a person's behaviour in a person-centred way to work out what the causes of that behaviour are and to see what we can change to enable that person to live as a valued member of a community.

End

Transcribed by Owen Elias

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