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 **Working with complexity**

* WORKSHOP AGENDA

- * Consider the complexities of HIV care and the challenges of providing care when there are psychosocial issues
- * Brief outline of attachment theory and how it can help us understand complex presentations
- * Think together about a complicated case
 - * How we might understand the person's behaviour
 - * How we might respond as clinicians in terms of managing complex care needs

* **Outline**

- *What makes providing care for PLWHIV complex?
- *What issues do you face within your clinical practice?
- *What solutions have you developed ?

***Thinking points for discussion**

* What makes care challenging in our clinical area ?

* HIV Historically complex area of work

* Changes to care since significant ART improvements

* Worldwide, national and local targets (medical and psychological)

* **Person centred care - idealism ???**

* **HIV Care Needs and Service Provision**

*What does person centred care mean to you?

*Why is this challenging for the cohort we provide care for ?

***Thinking points for discussion**

* Holistic person centred care/complex needs

* Complex needs can present/manifest in many ways

- * High psychological and emotional distress
- * Chaotic lifestyle, including drug use, alcohol use, chemsex.....
- * Adherence issues
- * Erratic clinic attendance
- * Difficulties in healthcare relationships
- * Comorbidity issues
- * Increased mortality
- * Cognitive function problems
- * Complaints and litigation

*** Complex Issues**

* COMMON SCENARIOS IN OUR CLINIC (anecdotal)

* People with complex needs:

- * Referred to psychology - don't engage
- * Revolving door referrals
- * Don't meet criteria for community mental health Services
- * Specialist Nurses holding risk - managing extreme complexity
- * Engage with Psychology - but not in right place for therapy
- * Consultant time taken up with long appointments
- * Joint working - but informal structures

* **Complex Issues**

* HOW CAN WE BEGIN TO ADDRESS THESE NEEDS?

- * Complex needs - MDT approach for inter-relating difficulties
- * Complex psychosocial needs have a strong relationship with early trauma (in relationships)
- * Issues can play out within a health care setting - we are now the caregivers!
- * Take this into account when planning and delivering care for people with complex needs
- * Attachment theory can help us understand these needs

* **Complex Issues**

* VERY BRIEF INTRODUCTION TO ATTACHMENT THEORY

- * Initially proposed by Bowlby (1969, 1973, 1980)
- * Theory of social and emotional development
- * In built drive to form affectional bonds with others

- * **Important in development of:**
 - * Cognition/thinking
 - * Self esteem
 - * Ability to cope in stressful situations

- * **Provides a general template for interpersonal/social relationships (Internal Working Models)**

* Attachment Theory

- * Attachment figures - generally the main caregivers
- * Goal of attachment - **Protection**, which is found in relationships that offer security and comfort
- * **‘Secure Base’ or ‘Safe Base’** (Ainsworth et al, 1978)
- * Children explore the world from the secure base (caregiver), coming back to safety when threat is encountered.
- * Attachment behaviours - crying, clinging, shouting out

* Attachment Theory

* Secure attachment

- * Developed with 'good enough' parenting:
 - * Consistent and sensitive in responding to child's needs
 - * Available to help child regulate emotions (e.g. fear and distress)
 - * Show empathy and support



* Patterns of Attachment

* Insecure attachment

- * When the conditions for 'good enough' care giving are not fully met - children spend time monitoring safety and security, rather than exploring and pleasurable interactions with caregiver

Insecure-avoidant

Caregivers

- Have difficulty responding to a child's needs
- Show anger, distress, fear, annoyance

Children tend to:

- Play down attachment behaviours
- Ignore or move away from caregiver (fear of negative consequences)

Insecure Ambivalent

Caregivers:

- Are poor at reading the child's attachment behaviours
- Unpredictable and inconsistent in their responses

Children tend to:

- Maximise attachment behaviours (to elicit care)
- Resist comfort (fear it will stop)

* Patterns of Attachment

* Disorganised Attachment

* When caregivers:

- * Are frightening (hostile, abusive, violent/aggressive etc)
- * AND/OR frightened (helpless, depressed, misusing substances)

* Children tend to:

- * Have no where to go for comfort/safety - cannot resolve trauma
- * Develop a range of control strategies to survive

- * These children are likely to display behaviour, which for them is adaptive to trauma, but that does not fit with social norms ('odd', aggressive, psychosis etc). They are also likely to develop negative and/or extreme beliefs about themselves (e.g. I am bad, worthless, evil, powerful.....based on caregiver responses to their attachment behaviour)

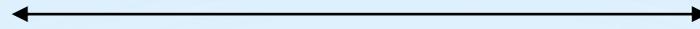
* Patterns of Attachment

*WE become the caregivers

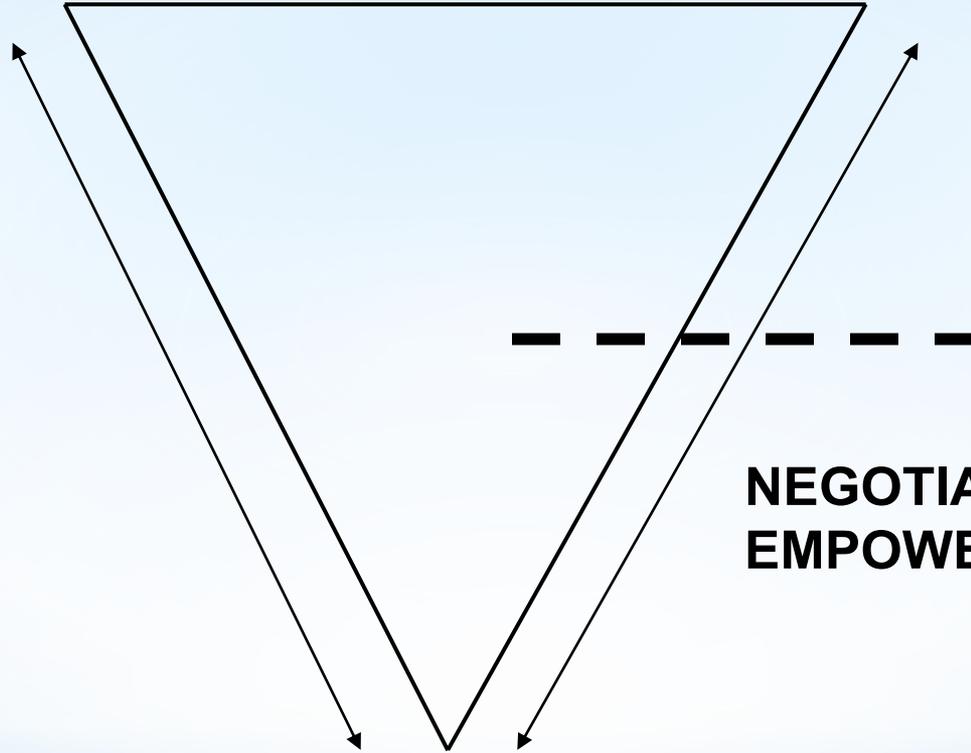
- * Because of the adverse template for relationships that the person has formed, these dynamics are likely to be played out within the healthcare setting and relationships
- * The person may **EXPECT** us to be abusive, dismissive, neglectful.....
- * Expectation will heighten sensitivity to subtle behaviours that can be misinterpreted through the lens of past abuse/neglect
- * Busy clinics may unintentionally trigger distress

* Attachment Theory and Healthcare

Abuser/aggressor



Rescuer



Victim

**NEGOTIATION AND
EMPOWERMENT**

***Dynamics Triangle**

*Time for us to think together.....

*Case Study