The Mirror Has 2 Faces

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Disclosure

- Nothing to disclose
Learning Objectives

- Describe typical treatment plans and likely outcomes of primary care and pain specialists
- Explain the comorbidities associated with chronic pain
- Cite the cross-sectional associations of patients with chronic pain
- Differentiate mechanisms of actions of tricyclic antidepressants from serotonin and norepinephrine reuptake inhibitors
Chronic Pain and Depression: Obvious but Disappointing

Introduction
The Usual Case

- 53 y/o woman w/low back pain and depression
- Pain in legs, R > L but hurts everywhere
- Mood is sad, frustrated, angry and cannot do anything
- Three L/S surgeries for discectomy, laminectomy, and fusion
- No longer able to work, husband is distant and friends have moved on
- Taking opioids on a variable schedule makes pain less horrible
- Intermittent injections help for a while, failed multiple medications
- Cannot tolerate physical therapy and stays at home most of the time
- Primary care physician started an SSRI without significant benefit
The Usual Treatment

- Surgeon: Consider removing hardware vs. extending fusion
- Anesthesiologist: Continue injections, consider spinal cord stimulator
- Primary Care: Continue SSRI, add muscle relaxant and sleeping pill
- Physical Therapist: Consider a gym membership to initiate exercise
- Psychologist: Learn better coping skills and attend a support group
- Emergency Medicine: Stop abusing drugs and do not return
- Attorney: Apply for disability and consider suing the surgeon
- Internet: Waste time talking to people with horrible outcomes
- Consultant: Seek the holy grail of causes & magic bullet of treatment
The Usual Outcome

- Pain and depression persist and worsen
- Medications increase in number and dose
- Psychosocial condition deteriorates
- Healthcare utilization increases
- Disability is received but constantly challenged
- Referred for urgent psychiatry consult for “suicidality”
- Spend more time on-line telling your own horrible story
- Refuse advice of consultants to pursue interdisciplinary rehabilitation
- Hope they are one of the 35% of patients that get 35% better in RCT’s
Depression and Chronic Pain

- General population: CP-16% vs. no CP-6%
- Increases dramatically in clinical samples
- Varies with patient sample and methodology
- Using rigorous RDC/DSM criteria: 30-54%
Cross-Sectional Associations

- Patients with chronic pain and depression
  - experience greater pain intensity
  - feel they have less life control
  - use more passive coping strategies
  - report greater interference from pain
  - exhibit more pain behaviors / disability
  - have poorer surgical outcomes
  - utilize more healthcare services
  - retire from work earlier
Longitudinal Relationships

- Specific etiologies remain a mystery
- Shared neurobiology but different pathophysiology
- Majority of the data support the diathesis-stress model (depression is a consequence of chronic pain)
- Treatment of depression improves pain and disability
Depression and Chronic pain

- 60% of patients with depression report pain symptoms at the time of diagnosis.

- After 8 years, depression was the best predictor of persistence of chronic pain symptoms in GP.

- Patients with depression are at twice the risk of:
  - Chronic daily headache
  - Atypical chest pain
  - Musculoskeletal pain
  - Low back pain
Differential Diagnosis

- The patient may be sick with a disease
- The patient may be in trouble from an inappropriate behavior
- The patient may be frustrated by his/her own vulnerabilities
- The patient may be demoralized by a particular stressor
Perspectives of Psychiatry Derivations from Sources

- **Disease**
  - What the patient *Has*
  - Derivation by Category

- **Dimensions**
  - What the patient *Is*
  - Derivation by Gradation and Quantification

- **Behaviors**
  - What the patient *Does*
  - Derivation by Goals and Choices

- **Life Story**
  - What the patient *Encounters*
  - Derivation by Narrative

McHugh & Slavney, 1998
Diseases

- Case 1: Etiology → Pathology → Syndrome
  - Abnormality in structure or function
  - Broken parts require fixing
Diseases: What Patients Have

- A broken part in the body or brain is generating a pathologic condition and its subsequent symptoms and signs, which include the way the patient is acting.

- The structure or function of a bodily part is transformed from normal to abnormal.

- Causal relationships explain “how” physiology becomes pathophysiology.

- Cures prevent or correct the abnormality.
Diseases: What You Should Do

- Search for all possible broken parts causing pathology
- Fix as many broken parts as completely as possible to minimize pathology
- Select treatments that will minimize new damage and subsequent pathology
- Avoid labeling the patient as synonymous with the defect
Case 1: Major Depression & Neuropathic Pain

- 53 y/o woman w/low back pain and depression
- Pain in legs, R > L but hurts everywhere with increasing weakness
- Mood is sad, frustrated, angry and cannot do anything
- Pain follows the L5 dermatome on the right with a burning quality
- Depression is unresponsive to positive life events with anhedonia
- Since being on increased amounts of opioids, depression is worse
- Low dose SSRI improved mood and motivation that waned over time
- Both gabapentin / pregabalin decreased pain but caused sedation
Case 1: Tailored Treatment

- Diagnoses of Major Depression and Radicular Neuropathic Pain made
- Plans for surgery and further interventions put on hold
- Ineffective medications lacking specificity tapered and discontinued
- SNRI was started and titrated over several weeks
- Anticonvulsant added for augmentation and titrated w/serum levels
- Husband encouraged and more supportive seeing improvement
- Spontaneous increase in ADL’s and return to exercising
- Discussions with employer about possible return to part-time work
Major Depressive Disorder

- Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning.
- At least one of the symptoms is either depressed mood or loss of interest or pleasure.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The episode is not attributable to the physiological effects of a substance or to another medical condition.
Major Depressive Disorder Symptoms

- Depressed mood most of the day, nearly every day reported or observed by others (sad, empty, hopeless)
- Markedly diminished interest or pleasure in all activities
- Significant weight loss or gain (5% per month) or decrease/increase in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate or indecisiveness
- Recurrent thoughts of death not just fear of dying, recurrent suicidal ideation, suicide attempt, or a specific plan for committing suicide
Major Depressive Disorder Critical Elements

- Sustained change in mood, self-attitude, and vital sense disconnected from varying circumstances
- Suicidality is not normal
- Anhedonia
- Deterioration in self-image
- Cognitive dysfunction
- Vegetative signs
  - Diurnal mood variation
  - Early morning awakening
Neuropathic Pain

- Loss of large diameter myelinated sensory afferent inhibition of nociceptive transmission
- Deafferentation hyperactivity in dorsal horn cells
- Central sensitization (increased gain)
- Ectopic impulse generation
  - sites of injury, demyelination, and regeneration
- SMP → sensitivity of primary afferent nociceptors
- Antidromic release of sensitizing neuromediators
Neuropathic pain

- DM
- PHN
- TGN
- PD
- SCI
- PAP
- CA
- EtOH / Toxins
- RSD / CRPS
- LBP / Trauma
- CVA / TBI
- MS / AIDS
- Migraine
- Medications
Antidepressant Antinociception

- NE and 5-HT: ↑ diffuse noxious inhibitory control
- Alpha-adrenergic: ↓ NE stimulation of receptors
- NMDA: ↓ neuronal hyperexcitability
- Sodium / calcium channel: ↑ membrane stability
Serotonin Reuptake Inhibitors

- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Paroxetine (Paxil, Pexeva)
- Sertraline (Zoloft)
- Vilazodone (Viibrid)

- Most commonly prescribed antidepressants
- Increases levels of serotonin in the brain
- Fewer side effects
- Safe in pregnancy
Serotonin Reuptake Inhibitors

- Excellent antidepressants
- Anecdotal efficacy for pain
- Fewer and less toxic side effects
- Multiple drug / drug interactions
Serotonin and Norepinephrine Reuptake Inhibitors

- Duloxetine (Cymbalta)
- Venlafaxine (Effexor XR)
- Desvenlafaxine (Pristiq)
- Milnacipran (Savella)
- Levomilnacipran (Fetzima)

- Increase levels of both Serotonin and Norepinephrine
- Rapid effects
- Independent effects on pain and mood
Serotonin and Norepinephrine Reuptake Inhibitors

- Dual reuptake inhibitors (5-HT, NE)
- No affinity for multiple receptors
- 5-HT:NE ratios of SNRIs:
  - venlafaxine = 30:1
  - duloxetine = 10:1
  - desvenlafaxine = 10:1
  - milnacipran = 1:3
  - levomilnacipran = 1:2
Tricyclic Antidepressants

- Amitriptyline (Elavil)
- Amoxapine (Asendin)
- Desipramine (Norpramin)
- Doxepin (Sinequan)
- Imipramine (Tofranil)
- Nortriptyline (Pamelor)
- Protriptyline (Vivactil)
- Trimipramine (Surmontil)
- Maprotiline (Ludiomil)

- Name is due to their chemical structure
- Multiple receptor affinities
- Generally increase serotonin and norepinephrine
- Significant side effects
- Lethal in overdose
- Helpful with pain
- Low cost
Antidepressants Summary

- **TCA’s are the old “gold” standard**
  - Toxicity, serum level monitoring, metabolic/CV effects

- **SSRI’s have been overly relied on**
  - Less efficacy in neuropathic pain, MDD still undertreated
  - Fewer side effects improve compliance
  - Disease management benefits (DM, CVD)

- **SNRI’s are the current focus**
  - Independent efficacy in RCT’s for CP & MDD
  - Norepinephrine a critical “co-factor” for neuropathic pain

- **Remission** of MDD has the greatest impact on CP
Case 1: Optimistic Outcome

- Depression remitted with positive emotions, optimism, and energy
- Pain decreased in intensity with residual pain “not interfering”
- Activity increased with gradual disappearance of myofascial pain
- Active exercise normalized body mechanics and increased strength
- Previous success in work used as a rationale to return to full-time
- Marital stress and financial problems improved with mutual effort
- Increased socialization with friends reinforced network of support
- No time for doctors’ appointments and Internet chat rooms
Case 2: Potential → Provocation → Response

- Quantifiable and measurable traits
- Inherent strengths and vulnerabilities

Dimensions
Dimensions: What Patients Are

- Personal features can be quantified along a continuous spectrum of measurement
- Inherent vulnerabilities are provoked by the setting
- The mismatch results in a physical or emotional reaction
- Guidance toward settings that utilize strengths will avoid having to rely on weaknesses
Dimensions: What You Should Do

- Obtain descriptions of who the patient was before their illness
- Recognize how much of each trait a patient possesses
- Remediation can “add” to a specific quantity
- Match the strengths of each trait with specific tasks to enhance capabilities instead of focusing on the vulnerabilities of deviance
Case 2: Introversion & Somatosensory Focus

- 53 y/o woman w/low back pain and depression
- Pain in legs, R > L but hurts everywhere
- Mood is sad, frustrated, angry and cannot do anything
- Pain is a dull ache w/tightness from hip down the outer thigh to knee
- Multiple somatic symptoms are noted in the Review of Systems
- Depression is anger with lack of progress and anxiety over symptoms
- Medications cause side effects and “just mask the underlying cause”
- Spending excess time cataloguing symptoms and exercising to stay fit
- Requesting more consultations to find the broken part and fix it
Case 2: Tailored Treatment

- Affective and anxiety disorders ruled out
- Pain work-up reviewed for completeness and lack of new signs
- Explained pre-morbid personality of an unstable introvert
- Provided a detail-oriented formulation of the persistent post-op pain
- Added that usual strengths of organization and fixing problems are now vulnerabilities that are provoking anxiety about failing herself
- Directed to stop collecting more information to improve S/N ratio
- Referred to a psychologist for biofeedback and relaxation training
- Increase frequency of follow-up to track condition and limit consults
Disposition

- Tendency to respond in a certain manner under particular circumstances
- An inherent and latent (hidden) characteristic evoked or brought to light by events
- Resemble physical dispositional attributes such as the solubility of a substance or the electrical resistance of a wire
- Psychological dispositions can elude attention if an extensive personal history is unavailable
Introverts and Extraverts

- Extraverts are "action" oriented, while introverts are "thought" oriented
- Extraverts seek "breadth" of knowledge and influence, while introverts seek "depth" of knowledge and influence
- Extraverts often prefer more "frequent" interaction, while introverts prefer more "substantial" interaction
- Extraverts recharge and get their energy from spending time with people, while introverts recharge and get their energy from spending time alone
Conditioning and Temperament

- **Extraverts**: Punishments fail
  - Poorly responsive to negative reinforcement
  - More responsive to positive reinforcement
  - Quick to de-condition (extinguish)

- **Introverts**: Rewards fail
  - Very responsive to negative reinforcement
  - Poorly responsive to positive reinforcement
  - Slow to de-condition (extinguish)

- **Unstable**: Disrupted by all negative reinforcers
Typical Provoked Responses

- Potential for strong emotional reactions
- Unstable extraverts
  - Explosive anger
  - Depressive sulking and finger-pointing (eLOC)
  - Disruptive responses to alcohol
- Unstable introverts
  - Prolonged depressive responses (demoralization)
  - Anxiety over change with anticipation of the worst
  - Obsessionality (‘dithering’) and scrupulosity
Introverts

- Internally focused
- Reflective
- Solitary
- Analytical
- Live in the past and future
- Punishment-averse

Cain, 2012
Introverts in Pain

- Prone to somatic preoccupation
- Wondering what is wrong
- Suffer in silence
- Detail-oriented
- What did you miss? What will go wrong?
- I don’t want to feel bad
Neurotics

- Tend to experience negative emotions
- High intensity emotions
- React poorly to stress
- Unpredictable reactions
- Easily threatened
- Sensitive to withdrawal of attention
- Dramatic catastrophizers
Neurotics in Pain

- Easily distressed
- Feelings dominate interactions
- Maladaptive coping
- Inconsistent
- Prone to attack
- Defensive
- The worst is going to happen
Helping the Introvert

- Need extra time for you to listen
- Provide more detailed information
- Discourage using the Internet
- Anxiety reduction techniques
- Careful physical examinations
- Minimize consultations
- Comprehensive plans w/predictable follow-up
- The body is not a machine easily fixed
Helping the Neurotic

- Avoid upsetting theorizing
- Behavior first, feelings second
- Model appropriate behavior
- Point out that the worst has not occurred
Treatment with Guiding

- The claim that these are untreatable rests on a conceptual problem of mistaking the dimensional foundation for the clinical issue.
- The dimension cannot be changed but the responses and their provocations can be addressed.
- Remediation adds experience to enhance skills.
Case 2: Optimistic Outcome

- Impressed by referral to an “expert” in biofeedback w/equipment
- Focused obsessionality on learning relaxation techniques “perfectly”
- Anxiety and somatic symptoms decreased with body scanning
- Rejected external information sources as not specific to her problems
- Reassured by more frequent appointments to update the doctor
- As pain and other symptoms receded, IP tendinitis & ITBS diagnosed
- PT prescribed specific regimen of rest, stretching, and massage
- Validated that there was something wrong but fixable
- Asked to decrease frequency of appointments to focus on work
Behaviors

- Case 3: Drive → Choice → Learning
  - Actions motivated by design and purpose
  - Complex behaviors result from personal choice
Behaviors: What Patients Do

- Certain behaviors can be problematic

- Behavior is the cumulative result of components interacting with a design and purpose

- A behavior has to stop before its components can be altered or shaped to prevent its relapse
Behaviors: What You Should Do

- Point out problematic behaviors every time they occur to promote change
- Insist the patient take responsibility for his choices to emphasize looking for options to stop undermining improvement
- Reinforce productive behaviors and their positive consequences whenever possible
- Look for all possible drivers of their actions not just placing blame
Case 3: Addiction and Avoidance

- 53 y/o woman w/low back pain and depression
- Pain in legs, R > L but hurts everywhere
- Mood is sad, frustrated, angry and cannot do anything
- Pain is centered in the low back and described as sharp w/movement
- Depression is feeling scared and being fearful of injuring herself
- Any attempt at trying to be functional makes the pain much worse
- Activity is followed by extended periods of rest and more medications
- All behaviors are marked by inconsistency and noncompliance
- When confronted, she feels overwhelmed and unable to cope
Case 3: Tailoring Treatment

- Expressed concern about the lack of a systematic approach
- Utilized Motivational Interviewing to initiate needed changes
- Developed a plan for stabilizing medication use (opioids, benzo’s)
- Described the syndrome of opioid-induced hyperalgesia
- Discussed the elements of rebound symptoms and withdrawal
- Added basic sleep hygiene techniques to improve insomnia
- Added visual imagery and self-hypnosis for anxiety reduction
- Referred to active PT for desensitization to increase range of motion
- Referred to Addiction Medicine specialist for group behavior therapy
Addiction: Disordered Function

- Loss of control of something you do
- Preoccupation with something you want to do
- Doing something despite adverse consequences
Impaired Control (compulsive use)

- Not able to take medications as prescribed
- Frequent requests for early renewals
- Reports frequent lost, stolen or destroyed Rx’s
- Cannot produce medications when asked
- Abusing non-prescribed drugs or alcohol
- Withdrawal signs or symptoms in clinic
Preoccupation (craving)

- Not interested in other recommendations
- Not interested in rehabilitation efforts
- Prescriptions from multiple sources
- Preference for specific medications, especially highly reinforcing medications
Use Despite Harm (unresponsive)

- Persistently intoxicated
- Persistently over-sedated
- Declining function due to use
  - Work
  - Relationships
  - Recreation
  - Health
Failure of Usual Care

- Inclination to confront or persuade patients with action plans prior to readiness to change does not work.
- A supportive relationship is the foundation.
- Talking is replaced by listening skills that evoke the clients’ natural use of language about change.
- Evoking clients’ own reasons to change minimizes their resistance.
Paradigm Shift

- Not getting people to do what therapists want
- Deficiency models seek to instill knowledge, insight, skills, correct thinking, motivation
- Helping people to explore their own values and motivations AND how these may be served by the status quo or behavior change
- Client autonomy to choose whether, when and how to change (You have what you need)
- Confidence in human desire and capacity to grow in positive directions (Find it together)
Definition of Motivational Interviewing

- A directive, client centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence
- A person-centered counseling style for addressing the common problem of ambivalence about change
- First described by Miller in 1983 and applied to the treatment of alcoholism
- MI is a particular way of helping clients recognize and do something about their current or potential problems
Usual Medical Applications

- Improving adherence to medical advice
- Instituting changes in lifestyle to modify risk factors
- Making patients aware of the potential for change in behavior resulting in improved health parameters
- Brief consultations
- Wide range of behavioral issues
- Generally robust effect sizes
Characteristics

- Identifying and mobilizing intrinsic values and goals to stimulate behavior change
- Motivation to change is elicited from the client and not imposed by the therapist
- Designed to elicit, clarify, and resolve ambivalence and to perceive benefits and costs associated with it
- Readiness to change is not a client trait but a fluctuating product of the interpersonal interaction
Characteristics

- Resistance and denial is often a signal to modify motivational strategies
- Eliciting and reinforcing the client’s belief in ability to carry out and succeed in achieving a specific goal is essential
- The therapeutic relationship is a partnership with respect of client autonomy
- A set of techniques and counselling style to elicit change talk and decrease sustain talk
Phases of MI

- **First phase**
  - interviewer focuses on eliciting change talk to elicit intrinsic motivation for change
  - when ambivalence is resolved, sufficient motivation appears and the interviewer transitions

- **Second phase**
  - strengthening commitment to change
  - focusing on converting motivation into commitment to specific change goals and plans
Guiding Principles

- Expressing empathy
  - Acceptance of what is
  - Understanding ambivalence is normal
  - Reflective listening to hear their own words

- Developing discrepancy
  - What is vs. what is personally wanted

- Rolling with resistance
  - Solutions reside within the client
  - Avoids criticism of where the client is

- Supporting self-efficacy
  - Understand beliefs about ability to change are directly related to their capacity for change
  - Provider believes in the client’s ability to decide when and how to make desired changes
MI Strategies

- Assessing Stages of Change
  - OARS: open-ended questions, affirmation, reflective listening and summarizing
  - Typical Day: description of current behaviors
- Ask-tell-ask to collaborate with self-expertise
- Pros-and-cons of both sides of behavior
- Self-efficacy and confidence in ability to change
- Importance of change
- Agenda setting = consider change
- Action planning = try change
Case 3: Optimistic Outcome

- Patient acknowledged wanting to change but lacking a plan or skills
- Standing schedules of benzodiazepines and switch to ER/LA opioids
- As adverse effects of medications subsided, engagement increased
- Sleep improved without medication
- Anxiety improved with mastery of relaxation techniques
- Increased energy and improved self-efficacy facilitated PT progress
- Group therapy reinforced new behaviors by confrontation from peers
- Patient acknowledged using medications as a poor coping strategy
- With improvement and stabilization, medication taper successful
Life Stories

- Case 4: Setting → Sequence → Outcome
  - Meaningful events and encounters
  - Interpretations of success and failure
Life Stories: What Patients Want

- Unintended consequences result from intentional actions
- Meaningful events accumulate to produce a narrative for understanding “why”
- Meaningful connections must be replaced with new interpretations to restore mastery
Life Stories: What You Should Do

- Expand the history to include every aspect of the patient’s life
- Understand what it means to the patient to suffer from chronic pain
- Help the patient find an answer to the question, “what good does life hold for me?”
- Recognize there is not just one “true” story
Case 4: Grief and Catastrophizing

- 53 y/o woman w/low back pain and depression
- Pain in legs, R > L but hurts everywhere
- Mood is sad, frustrated, angry and cannot do anything
- Pain is variable from being pain-free to severe with associated fatigue
- Depression is episodic with crying spells when remembering health
- At her worst, pain is uncontrollable and the situation is hopeless
- She has alienated her support system with intrusive distress
- Her husband notes she always “flies off the handle for no reason”
- Her work was a source of pride and validation of her success in life
Case 4: Tailoring Treatment

- Explained the reactive state of demoralization and grieving process
- Normalized negative feelings as legitimate and needing validation
- Introduced the concepts of acceptance and value-based goals
- Discontinued PRN’s (muscle relaxants, NSAIDs, sleep aids, tramadol)
- Referred for interpersonal psychotherapy to include her husband
- Redirected previous work skills in sales to learning catastrophizing
- Developed problem-solving self-talk for rumination and helplessness
- Referred to Occupational Therapy and Vocational Rehabilitation
- Found a support group for professionals changing careers in mid-life
Personal Stories

- Each person has a sense of potential or hope for what he or she wants out of life

- A series of events may result in which hopes have not been realized or potential not fulfilled

- Demoralization occurs when the patient reaches a meaningful realization that some aspect of their personal life is a failure
Bereavement: Studies in Grief in Adult Life Parkes, 1972

- Phases of grief (Bowlby and Parkes)
  - Numbness with disbelief and searching
  - Pining (pangs of grief) with apathy and anxiety
  - Disorganization/despair with repetitive review
  - Reorganization with return of normal drives

- Behaviors of grief
  - Searching (immediate)
  - Wellings (evoked)
  - Loss of drive (less than 3 months)
  - Repetition of events (3-9 months)
Components of Grief

- Urge to look back, cry, and search for what is lost
- Urge to look forward, explore the world that now emerges, and discover what can be carried forward from the past
- Social, cultural pressures influence how the urges are expressed or inhibited
Determinants of Outcome

- Circumstances of the life-changing event
  - Anticipation, massive or multiple changes, brutal or violent events

- Personality and previous experience
  - Self-confidence, success/failure of resolutions of earlier transitions

- Factors impinging after the event
  - Social support, opportunities for new roles
Types of Loss

- Loss of innocence or novelty
- Examples
  - Breaking a vow, committing a crime
- Result from first experiences
- Regret is highlighted
- Experience is gained
- Courage is the achievement (venture)
Types of Loss

- Loss of affiliation or familiarity
- Examples
  - Leaving home, divorce
- Result from separations
- Yearning is highlighted
- Potential is gained
- Temperance is the achievement (restraint)
Types of Loss

- Loss of a cherished possession/identity
- Examples
  - Aging, illness, retirement, amputation
- Result from neglect or entropy
- Disappointment is highlighted
- Appreciation is gained
- Prudence is the achievement (reason)
Types of Loss

- Loss of love
- Examples
  - Death, atrocity
- Result from the unthinkable
- Hopelessness is highlighted
- Fulfillment is gained
- Justice is the achievement (morality)
Elements of Intervention

- Helpers as agents of change
- Access to expertise (practitioner, peer)
- Support (time, compassion, counsel, ritual)
- Distress reduction (multiple modalities)
- Preparing for the event (education, guidance)
- Build self-efficacy (confidence, optimism)
- Practice (reflection, association, simulation)
Treatment Prior to Loss

- Guidance requires time
- Prepare the person for the loss
- Listen to what is already known
- Invite questions & provide direct answers
- Monitor what is understood
- Permit and normalize their reactions
- Let the person control the amount and flow of the information they can handle
Treatment after Loss

- Emotional support from close associates
  - Those who are also grieving the deceased
  - Those who are grieving for the survivor
  - Those who are going through similar grief

- Ritual guidance from religion
  - Support for interactions with the deceased
  - Blessing and forgiveness for guilt
  - Maintain social interactions with others
Treatment after Loss

- Therapy from professionals
  - Review relationships with the deceased
  - Recognize alterations in emotional reactions
  - Work through negative feelings
  - Allow expression of sorrow and sense of loss
  - Formulate an acceptable future relationship to the deceased
  - Find primers for the acquisition of new patterns of conduct
Grief therapy as Work

- **Task theory** (Worden)
  - Accept the reality of the loss (reject denial)
  - Experience the pain of grief (avoid withdrawal)
  - Adjust to a changed world without the deceased (engage challenges)
  - Withdraw emotional energy and reinvest (embrace others)
The Grieving Process

- Not a process of waiting out a series of predictable emotional transitions
- An individual period of action
  - reconstructing a personal world of meaning that has been challenged and
  - affirming a life that is forever transformed by loss and
  - renewing oneself with the gains of hard work and achievements realized
Case 4: Optimistic Outcome

- Grief improved with less frequent crying spells and losing control
- Re-scripted life story with a focus on new potential for success
- Built a support network of professional women sharing techniques
- Started her own business and non-profit resource center for pain
- Focused on martial therapy with themes of complimentary strengths
- Settled WC claim to eliminate distractions and negative stress
- Stopped all medications citing more confidence in “doing it myself”
- Developed a “toolkit for pacing” to avoid depleting her “gas tank”
Conclusion
Hierarchical and Interactive Levels of Mental Life

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Treatment Principles and Risks

- **Diseases**
  - Fix the broken parts to restore function
  - All repairs cause damage

- **Dimensions**
  - Guide toward strengths to restore balance
  - All guidance is paternalistic

- **Behaviors**
  - Interrupt the acts to restore drives/goals
  - All demands to stop acting are stigmatizing

- **Life Events**
  - Interpret meanings to restore mastery
  - All interpretations are hostile
References

References

- Benzo RP. Mindfulness and Motivational Interviewing: Two candidate methods for promoting self-management. Chron Respir Dis 2013, 10:175-182
References

- Miller WR, Rose GS. Toward a Theory of Motivational Interviewing. Am Psychol. 2009, 64:527–537