Brief Psychotherapy at the Bedside: Existential Neuroscience to Mobilize Assertive Coping

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For severely ill patients, understanding the neurobiological underpinning of assertive coping provides an additional map for rapid assessment, formulation, and intervention to bolster assertive coping. It does not replace but complements other psychotherapeutic tools that can be implemented in brief encounters.

There is increased recognition that demoralization, as a normal syndrome of distress, is more commonly to blame for medically ill patients feeling overwhelmed and despondent than is depression. Patients who are “worn down and worn out” are common among the hospitalized medically ill. The medical prognosis for long-term functional recovery may be dismal. Moreover, mild encephalopathy from metabolic factors is compounded by the acute stress of pain, nausea, or insomnia, together with the chronic stress of uncertainty and waiting.

Patients coping with severe illness can become so apathetic that they lose their capacity to be motivated by either pleasure or pain. Advances in palliative care and the design of disease-specific psychosocial programs can offer compassionate, tailored treatment programs for patients with medical illnesses, often preventing demoralization.

CASE VIGNETTE
Mr Renshaw, 71 years old, has suffered for 2 decades with diabetes mellitus complications, including retinal deterioration and renal failure requiring dialysis. For the past 2 years, he has been on disability from his work as a chef. He is currently recovering slowly from a below-the-knee amputation, and his internist worries that he has become careless in monitoring his blood glucose—he seems to have given up.

For patients who have become demoralized, bedside psychotherapeutic approaches focusing on existential themes—hope, purpose, agency, communion with others, courage, gratitude—and other sources of person-focused resilience, such as accessing spiritual resources, have been found effective for rebuilding morale. However, a hospital medical service can be a hostile environment for bedside psychotherapy. Referrals for psychotherapy often originate from an internist’s or treatment team’s concerns, rather than a patient’s request. The fluctuating course of a medical disease and its treatments often hinder the scheduling of regular psychotherapy sessions. At times, psychotherapy may be limited to only a single session.

Bedside psychotherapy for demoralized patients must be timeefficient to be conducted within the routine flow of medical treatment despite its disruptions. A clinician must be able to form a therapeutic alliance within minutes after first meeting. Bedside psychotherapy must be flexibly inclusive of a broad range of patients, clinical settings, and illness conditions. Most important, it must be able to rouse an emotional response from a highly stressed, apathetic patient.

Existential neuroscience offers a new perspective for conducting bedside psychotherapy that can contribute to its greater effectiveness, efficiency, and portability across clinical settings. Existential neuroscience studies brain operations that connect a person’s subjectivity and meaning-making with the capacity to act effectively within one’s relational world. It conceptualizes how experience is embodied within brain circuits and signaling pathways whose integrity opens or closes portals for a sense of coherence, hope, agency, purpose, or communion with others. Existential neuroscience provides an understanding of the neural infrastructure for assertive coping. This additional clinical map can further optimize the effectiveness of bedside interviews with demoralized patients, particularly when conditions for psychotherapy are adverse.

Existential neuroscience and assertive coping
Demoralized patients have lost a capacity for assertive coping. Assertive coping refers to capabilities for confronting adversities of illness in a goal-directed and problem-solving manner, rather than...
avoiding, withdrawing from, or submitting to them. Failing to cope assertively with a medical illness and its treatment often prompts a psychiatric consultation “to treat depression.” Failure to cope assertively can become life-threatening when an overwhelmed patient becomes too apathetic to get out of bed, to participate in physical therapy, or to help monitor symptoms or medication adverse effects.

Whereas demoralization and depression are categorical diagnoses, selecting assertive coping as the behavioral outcome for intervention enables the conduct of psychotherapy to be guided by a dynamic understanding of emotion regulation and responsivity to stress. Understanding how information is processed under extreme stress matters most when the brain is also metabolically compromised with slowing of processing speed and impairments in its most complex systems—executive functions, focused attention, and social cognition.

Coping assertively despite extreme stress requires an override of automatic fight, flight, or freeze responses that ordinarily occur as stress reactions. This override is normally provided by a dorsal regulatory system consisting of the prefrontal cortex, the dorsal cingulate cortex, and the hippocampus. This dorsal system provides “top-down” regulation over ventral structures that are generating “bottom-up” emotions in response to aversive stimuli—the amygdala (fear), ventral anterior cingulate cortex (suffering from pain), and insula (disgust). Under normal conditions, the dorsal regulatory system can inhibit avoidant behavioral responses mobilized by the ventral system. This regulation is conducted through multiple mechanisms, including attention deployment, cognitive reappraisal, and behavioral suppression. However, this dorsal regulatory system can be disrupted by either metabolic effects of disease or extreme stress, or by both compounded. The region of the brain that is most vulnerable to stress exposure is the prefrontal cortex. Stress that maximally activates the amygdala/ventral anterior cingulate cortex/insula systems can produce an emotional load of such degree that executive functions are impaired. A dysfunctional prefrontal cortex cannot conduct effective goal setting, organizing, and planning, which are prerequisites for assertive coping.

Under conditions of extreme stress, a battle for dominance ensues between top-down regulation by the prefrontal cortex/dorsal cingulate cortex/hippocampus and bottom-up information processing by the amygdala/ventral anterior cingulate/insula. On the whole, high levels of emotional arousal tilt information processing to “bottom-up” processing with behavioral responses that are reactive to raw sensations.

This basic neuroscience model can be translated into clinical practices. Restoring competent executive functions requires a bolstering of emotion regulation. Options for bolstering a patient’s emotion regulation include directly reducing physical distress (physical pain, insomnia, pruritus, nausea), adding self-soothing and comfort measures, and increasing supportive relationships.

**Step 1: Discern the patient’s priority of concerns**

The consultant psychiatrist asked Mr Renshaw what his greatest concern is. “I’m going through a divorce,” he responded. “That and everything else [motioning at his amputated leg].” He spoke about the many losses he had sustained during recent years. From the moment of entry into the patient’s room, meeting the patient as another person takes precedence over any other agenda. This entails learning about the patient’s priority of concerns: What is your greatest concern? What’s the next most? Validating feelings of low mood and normalizing distress support a focus on the person, rather than a focus on psychopathology. As Slavney stated: “I point out they [demoralized patients] are not machines and that anyone in their circumstances might become disheartened.”

**Step 2: How has this illness affected you? How have you responded?**

“When you start to feel overwhelmed by your illnesses and family stresses, where does that take you? What is it like?”

“Alone,” Mr Renshaw responded, “I just feel alone.”

“That must make dealing with the diabetes and all else you’ve been through medically twice as hard. How have you dealt with the aloneness?” the consultant asked.

Mr Renshaw said that he once had met a few times with a professional counselor and felt less burdened when he has someone with whom he can speak openly. It was for this reason that he had agreed to meet with the consultant when his internist had recommended it. The consultant wondered whether Mr Renshaw was someone who, although a private person, coped best when in dialogue. “When you are facing hard struggles, is it easier when you can share your experiences with others?”

Mr Renshaw said that he in fact tended to be shy and private. However, he found the psychotherapy with a professional meaningful because otherwise he would not have been able to talk about these
things with family or friends.
When assertive coping is failing, assessment is needed to gauge where and how to focus an intervention. Two key questions can help clarify this. The first question asks about the impact of illness: How has this illness affected you? This question typically elicits a narrative of loss, trauma, and vulnerability. Variations on this question include: What is this illness like for you? What has this illness taken from your life? What is not happening in your life that would be happening were it not for this illness?

The second question asks: How have you responded? This question typically elicits a narrative of skills, competencies, practical knowledge, and other potential sources of resilience. It suggests what may have been signature strengths of the patient when healthy. The answers indicate the style of the patient’s coping, whether he or she first responds to stress by individual problem solving or by coping relationally—seeking others for help. A patient who historically has responded to crises by turning first to personal strengths and problem solving will likely respond best to strategies building on individual efforts. With the latter response, it is usually more fruitful to prioritize relational coping strategies.

**Assessment, formulation, and intervention**
An assessment of how a patient has responded to current and past adversities may suggest what the patient’s “strong suits” are for coping. Building on a patient’s most competent coping strategies is usually most fruitful.

The consultant wondered whether there were other existential dimensions that mattered in addition to loneliness. “What kept you from giving up when the stresses of illness and divorce were hardest?” he asked.

At times, Mr Renshaw had thought about suicide. However, he was determined to stay alive because his children needed a father. He had lost his father as a small child. He knew what that was like for a boy, and he wanted his sons to have a father in their lives. He also spoke about his faith in God’s presence in his life.

The consultant offered to arrange an appointment in a low-fee clinic that provided psychotherapy, which Mr Renshaw accepted. He also suggested a support group for divorced spouses in a church, about which Mr Renshaw felt less certain but agreed to consider. Mr Renshaw expressed confidence that he could and would meet with the psychotherapist.

Pathways thinking and agency thinking are cognitive strategies that constitute the heart of assertive coping. Pathways thinking is the capacity to envision a desired future and to imagine potential paths to reach it, together with steps along those paths. For someone with a chronic medical illness, this means imagining a life worth living despite the ongoing presence of illness. Agency thinking is closely akin and describes actions a person can take to build confidence that effective action is possible. Cognitive psychologists have operationalized “hope” as a product of pathways thinking and agency thinking. Antonovsky has referred to confidence that the adversity is comprehensible, manageable, and worthwhile confronting as a sense of coherence, which predicts health.

At bedside, a critical question is whether a patient can imagine pathways to reach goals set by his priorities of concern: When you think about your greatest concern, can you imagine what a good outcome would look like? What would you consider realistic to hope for? What would be a first step that you could take to make that outcome more likely?

Agency thinking can be bolstered when the patient is encouraged to speak directly from first-person experiences of living. These are often questions about motives, values, commitments, and identities:

What else should I know about you as a person apart from your medical diagnosis? What has kept you going on your hardest days? For whom, or for what, is it important that you survive this illness and return home? What does it say about you as a person that you have continued to strive to recover? In your heart of hearts, who do you know yourself to be? What does that say about the way that you face this illness?

Diagnostic assessment is needed when a patient is unable to envision pathways to a desired future or is so lacking in desire, motivation, or passion that problem solving is impaired. Impaired pathways thinking and agency thinking can result from markedly dissimilar processes: apathy, from metabolic encephalopathy, depression, negative symptoms of psychosis, or avoidance symptoms of PTSD; lack of knowledge about the medical condition and its treatments; marginalization within family, community, or social network; and inadequate financial or other resources.

Accurate formulation is critical. For example, organizing a community of support is an effective way to help a patient sustain a sense of agency when isolation or marginalization has been the problem. Antidepressant medication can be effective when the problem is apathy from depression. Educating the family and treatment team about neurological apathy can help fashion family assistance and
nursing care that does not rely on the patient’s motivation. Diagnosis and correction of metabolic abnormalities might have been the most direct path to strengthening his assertive coping had Mr Renshaw shown impairments on bedside cognitive testing. Apathy can be a final common pathway for multiple unrelated etiologies.

Relational coping is a common bedside response to adversity. Many individuals turn first to important relationships, rather than to individual problem solving. In humans, as well as other mammals, relationships powerfully regulate fear, helplessness, and other negative emotions.13,16 Pragmatically, they also engage additional people who can help solve problems. Impaired relational coping also can result from markedly dissimilar processes: apathy, from metabolic encephalopathy, depression, negative symptoms of psychosis, or avoidance cluster symptoms of PTSD; logistical obstacles to family or friend visits; relational cutoffs due to alienated friends or family members; patient’s efforts to hide distress to protect loved ones from witnessing his suffering; emotion dysregulation that alienates family members and friends.

Aiding a patient who uses relational coping begins by assessing which types of relationships matter most and how, then reestablishing access to that relationship or reproducing its function by using members of the treatment team as proxies. Questions that assess relational coping include1,4:

- This is a difficult illness to face alone—who do you most want to be with you as you face this illness and deal with it?
- On your most difficult days, who do you turn to?
- Who knows what you are really going through? Who do you talk with about your illness?
- In whose presence do you most feel at peace?
- For whom does it matter that you recover from this illness?
- To whom do you most want your life to make a contribution after you recover from this illness?

Responses to these questions indicate which kinds of relationships are most important. Each operates differently in providing emotion regulation and practical support for coping: attachment relationships, whose presence provides a sense of security and confidence; confiding relationships, with whom it is possible to speak openly and honestly; group or family role relationships, such as father or mother, brother or sister, team leader, or partner, whose roles and responsibilities are ones on which others rely; social network relationships, such as friends, neighbors, and colleagues who one can rely on for practical necessities; altruistic or generative relationships, as the individuals whom one nurtures, mentors, or provides sustenance to.

Hospitalizations too often strip patients from their vital relationships. Yet the missing relationships or their functions often can be restored, depending on the type of relationship and its role in coping. Some examples of relational interventions include facilitating hospital visits by important attachment or confiding figures, whether parents, children, siblings, partners, or lovers, either in person or by telephone, e-mail, or Skype; helping a patient to reassert a family or work group role, such as supporting an elderly patient’s position of family leadership during an improvised family meeting that discusses illness-related issues; organizing a community of support to address an ill patient’s practical concerns, such as attending to well-being of pets, house plants, or home maintenance while the patient is hospitalized; facilitating a patient’s efforts to contribute to the lives of others, whether by kindnesses shown to other patients or by phone calls or e-mails to individuals outside the hospital.

For patients with active religious lives, prayer and spiritual practices provide confiding and/or attachment relationships with the Divine. Churches, synagogues, mosques, and temples constitute social networks that can provide group roles and responsibilities as well as opportunities for altruism.3 A creative consultation-liaison psychiatry service can replicate the roles of confiding relationships and social network relationships when patients are physically cut off from contact with familiar relationships.

**Conclusion**

Understanding the neurobiological underpinning of assertive coping provides an additional map for rapid assessment, formulation, and intervention to bolster assertive coping. It does not replace but complements other psychotherapeutic tools that can be implemented in brief encounters. Existential neuroscience provides an integrative model that describes how salutary effects of dissimilar biological and psychosocial interventions converge at the level of brain circuits, whether these are the use of spiritual resources, psychoeducation, a social network, or medications. In particular, this neuroscience perspective highlights the additive effects of metabolic brain impairment and stress-induced compromise of executive functions when assertive coping is failing. It underscores the importance of bolstering emotion regulation even though the desired end-effects are cognitive ones.
To cope assertively with renewed morale is to live as fully human. In this manner, existential neuroscience can help further a humanistic mission to restore personhood despite the ongoing stresses of disease.

**Disclosures:**

Dr Griffith is Leon M. Yochelson Professor and Chair and Dr Gaby is Clinical Assistant Professor in the department of psychiatry and behavioral sciences at The George Washington University School of Medicine, Washington, DC. The authors report no conflicts of interest concerning the subject matter of this article.

**References:**


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