

# Physical Health and IPT

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Hopes for the day



# Some of the reasons MDTs need to consider the psychological

Poorer QoL related to:

- Worse symptom control
- Premature death
- Poor adherence
- Lower employment status
- Increased

Admissions (in, out & ER)

DNAs

Consultations

Length of stay

Healthcare costs

Risky behaviour

Depression weakens immune functioning

Stroke rates 2x higher in depressed people

Multiple studies in cardiac patients reveal

strong impact of depression (increased risk

of heart attack, more surgeries, predictive of

future problems)

Studies show depressed people die earlier

# The physical expression of emotions

Nausea

A clenched jaw or fist

Diarrhoea

Gut feeling

Headaches

'Getting on my nerves'

Heart-broken

'Feeling sick with worry'

Tight shoulders

Immune system functioning

Weight changes

Pain

# Plan for the day

Biopsychosocial  
model of health

The sick role

Attachment &  
physical health

The impact of  
trauma on  
physical health

Alexithymia

Polyvagal  
theory

The mind-gut  
axis

Case studies

Integrating all  
this into IPT



**Reflection time**

# Physical health traditional medical model misses:

Information about the person's psychological state

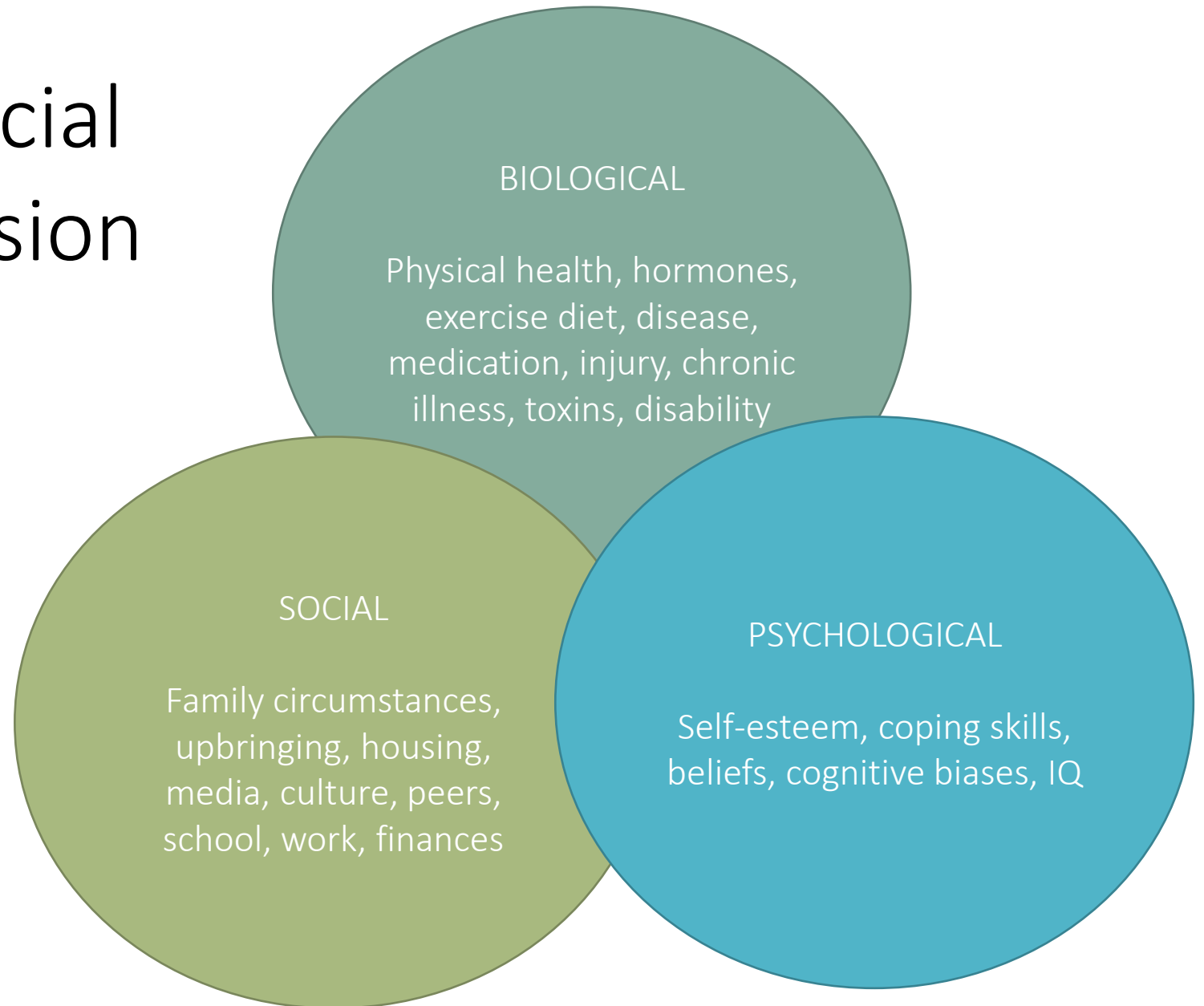
AND how it interacts with

How the physical condition develops

What the subjective impact is on the individual

How that individual manages their condition

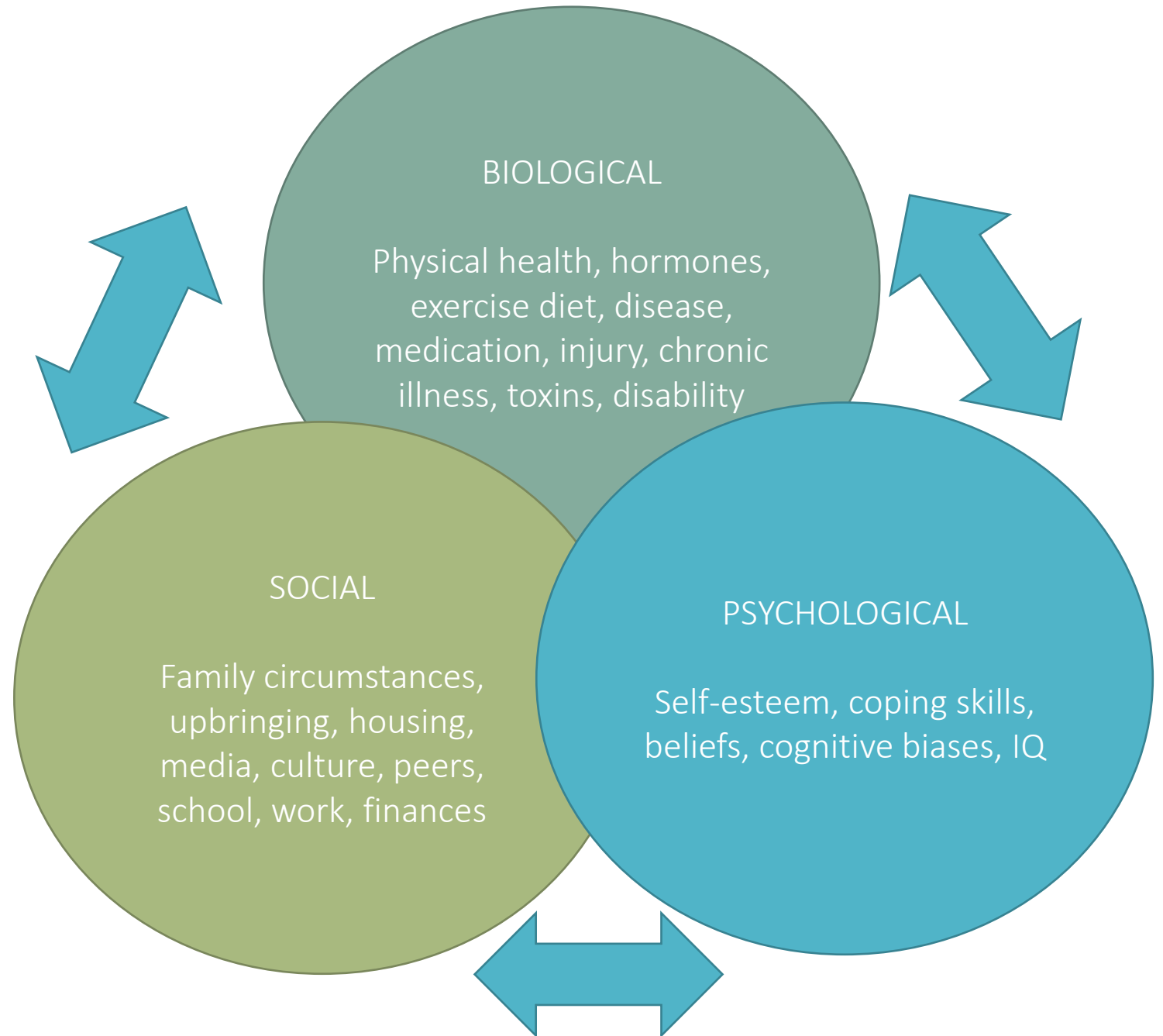
# The biopsychosocial model of depression



What are the dangers of us as therapists treating the mind and body separately?



More  
reciprocal –  
would look  
like ...



Where does physical health 'fit' within the framework for IPT?

# Social determinants of health

- UK based Whitehall study (Marmot et al, 1991 ) higher mortality associated with lower occupational ranking
- Not just about income ( but variables that decline in strength lower down social ladder)
- SES and inequalities associations with renal disease, breast cancer, childhood obesity, cardiometabolic health (Cockerham et al , 2017)
- Theories aim to explain the mechanisms via inequalities in SES, the environment, gene-environment interaction, social connections

*Marmot M, Smith GD, Stansfield S, et al. Health inequalities among British civil servants: the Whitehall II study. Lancet. 1991;337(8754):1387–1392. [http://dx.doi.org/10.1016/0140-6736\(91\)93068-K](http://dx.doi.org/10.1016/0140-6736(91)93068-K). [PubMed] [Google Scholar]*

*Cockerham W C, Hamby B W & Oates G R. The Social Determinants of Chronic Disease. American Journal of Preventative Medicine. 2017 Jan 52 (1Suppl1) S5-S12.*

## Values of social connectedness

Social capital theory highlights benefits individuals accrue via participation in social groups:

- The more invested in a group, the more benefits
- Subjective (feels good, belonging)
- Objective (advice, help, access to services)
- Offers reciprocity (transport, caregiving)
- Positive (and less positive) influence on health behaviours
- Mitigate the stress induced by chronic ill health

# Exceptions?

Social learning impacts upon a person's belief about illness and treatment and how they respond behaviourally

Can cause the patient to think differently about their condition in terms of onset, treatment & chronicity

How culturally acceptable might it be to have a particular illness ( shame)

Sex and age stereo types also affect how a person responds to their illness

(think male gynocomastia, primary ovarian insufficiency)

# Loneliness and physical health

High rates of loneliness in chronic illness.

Especially among older people who reported they felt left out, isolated or lacked companionship,

Loneliness among older people linked to:

Decline in the ability to perform daily activities like bathing, grooming and preparing meals

Increased risk of heart disease, arthritis, type 2 diabetes, dementia and even suicide attempts

Loneliness may be a preclinical sign for Alzheimer's disease:

a link between the participants' score on a three-question assessment for loneliness and the amount of amyloid in their brains. Amyloid accumulation is considered a main pathological sign of Alzheimer's disease.

# What are the physical effects of loneliness

High blood pressure

High cholesterol

Obesity / poor nutrition

Vasoconstriction

Increased cortisol

Increased interleukin

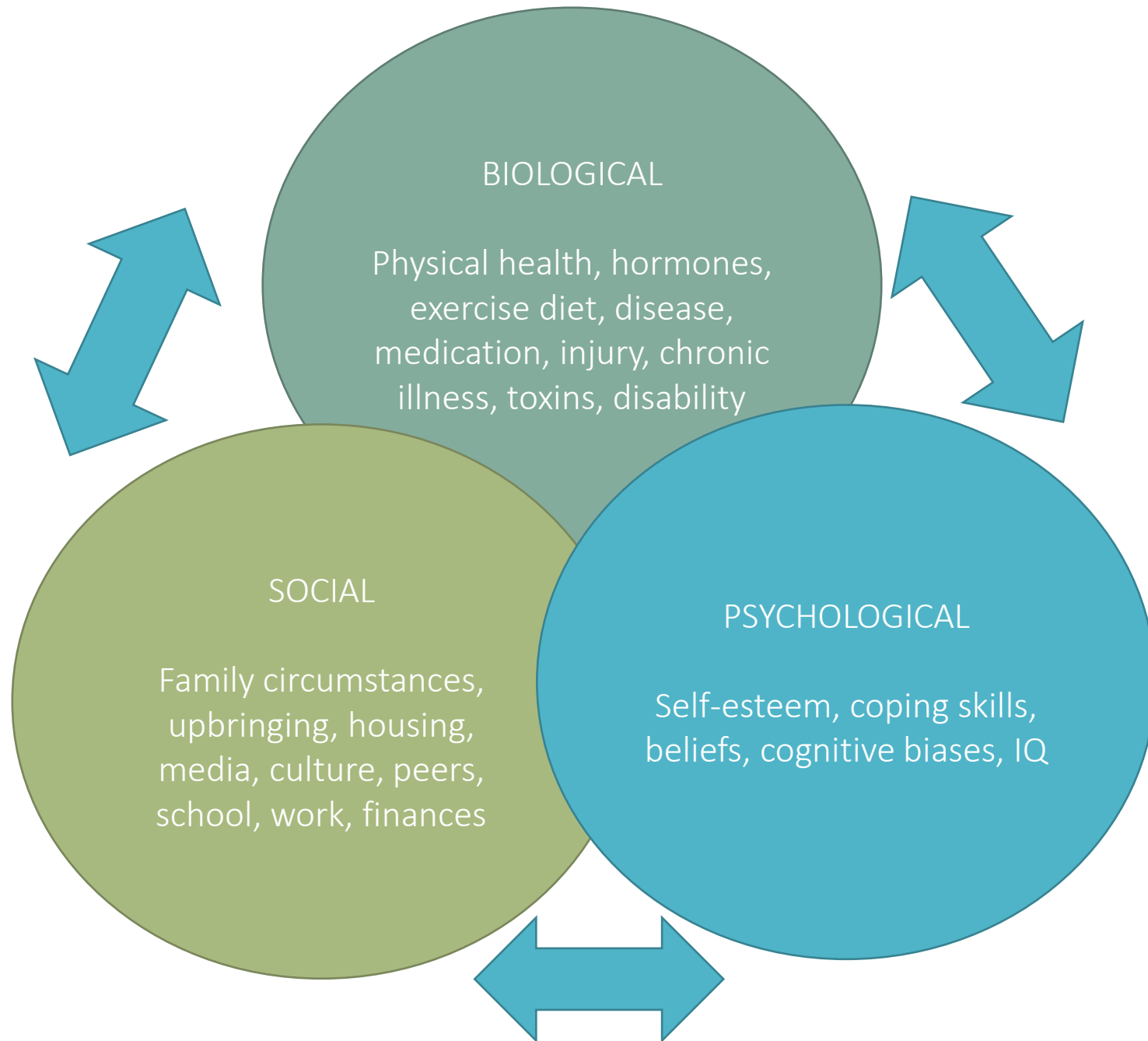
Increased inflammatory response

Prolonged, high cortisol levels can cause anxiety, depression, digestive problems, heart disease, sleep problems, and weight gain

Behavioural changes: Deficits in self-care and motivation, and shortfalls in nutrition, exercise and personal hygiene

[www.rcn.org.uk](http://www.rcn.org.uk)

*Khullar, D (2016) How Social Isolation is killing us. New York Times*







## Psychological factors

# Physical health and attachment (recap)

- Physical illness provides a ripe and often repeated opportunity for caregivers to provide (predictable) proximity and the soothing and containment of stressors.
- The repeated interactional experiences lead to an Internal Working Model of attachment being developed.
- The IWM are schemata that organise cognition, emotion and behaviour in relationships, essential for the development of stress regulation and resilience.
- On a cognitive level they comprise a model of self and others which determines the extent to which
  - worthy of support and proximity from others
  - confidence in receiving support from others

# Physical health and attachment

On a regulatory level IWM also determines information processing:

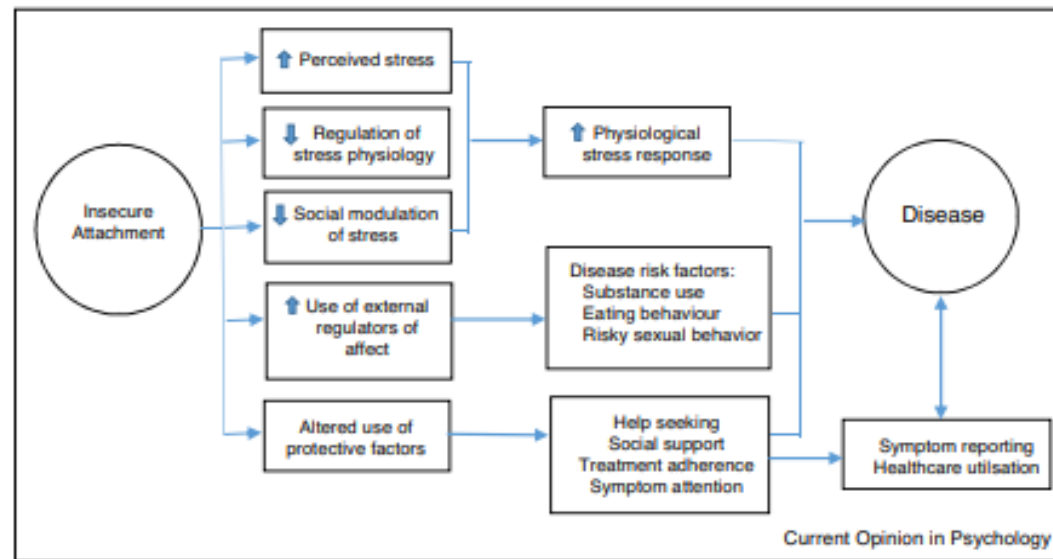
- Hyperactivation ( attachment anxiety)
- Deactivation ( attachment avoidance)

Impact on self, relationships, healthcare relationships and usage (enhanced=anxiety, reduced = avoidance)

*Ehrlich, K & Cassidy, J (2019) Attachment and physical health; introduction to a special issue. Attachment and human development, Vol 21, (1) 1-4.*

# Model of attachment and 'disease'

Meredith, PJ & Strong, J (2019). *Current opinions in Psychology*, 25, 132-138



Model of hypothesized mechanisms by which attachment insecurity could contribute to disease ([19] p. 561, used with permission).

# Assigning the sick role \*in physical health\*

According to Parsons' sick role model (1951), the sick person can be expected to be afforded two conditional rights, which could be withdrawn if obligations were not fulfilled.

Rights: 1. The sick person is temporarily exempt from performing 'normal' social roles (working, chores etc). The more severe the sickness, the greater the exemption.

Rights 2. A genuine illness is seen as beyond the control of the 'sick person' and not curable by simple willpower and motivation. Therefore, the sick person should not be blamed for their illness and they should be taken care of by others until they can resume their normal social role. \*

Obligations: 1. The sick person is expected to see being sick as undesirable and so are under the obligation to try and get well as quickly as possible. \*

Obligations 2. After a certain period of time, the sick person must seek technically competent help (usually a doctor) and cooperate with the advice of the doctor in order to get better.

# Group discussion: sick role

How might this be for an individual with physical health condition who has become depressed?

What impact might the 'condition' have on relationship with sick role?

Have they already assigned themselves/been assigned a sick role and how might they feel about it?

What other language might we use to invite/frame the sick role?

# Small group reflection: You and the sick role

What do our own sick roles look like?

How does your sick role affect your relationships?

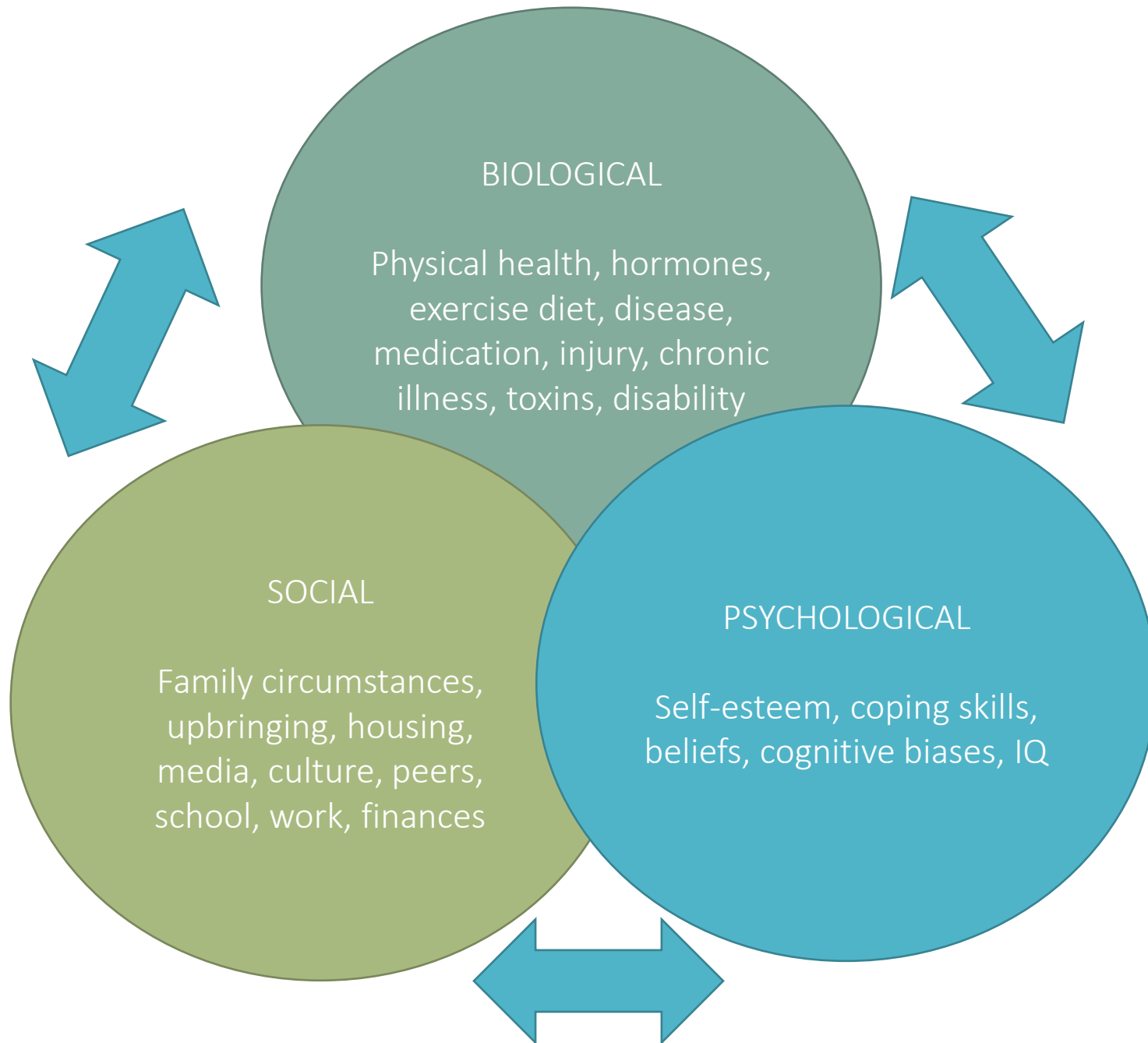
How might it be different if 'sickness' is acute or chronic?

Does it make a difference if the 'sickness' is socially acceptable?

Does it make a difference if the 'sickness' is visible or invisible?

What barriers/blind spots do we as clinicians have regarding sick role?

What assumptions /bias' might you have e.g. gender or age or other factor?





# Trauma/ACEs

‘The most important study you’ve never heard of’

- The largest study of its kind ever done to assess the long-term health impact of childhood abuse
- 15 year follow up
- 50+ publications
- Over 17,000 individuals were included in the study
- Over two-thirds of respondents had at least one ACE

The Adverse Childhood Experiences Study  
(Felitti, Anda & Norderberg, 1998)

# The Adverse Childhood Experiences (ACE) Study

## Summary of Findings:

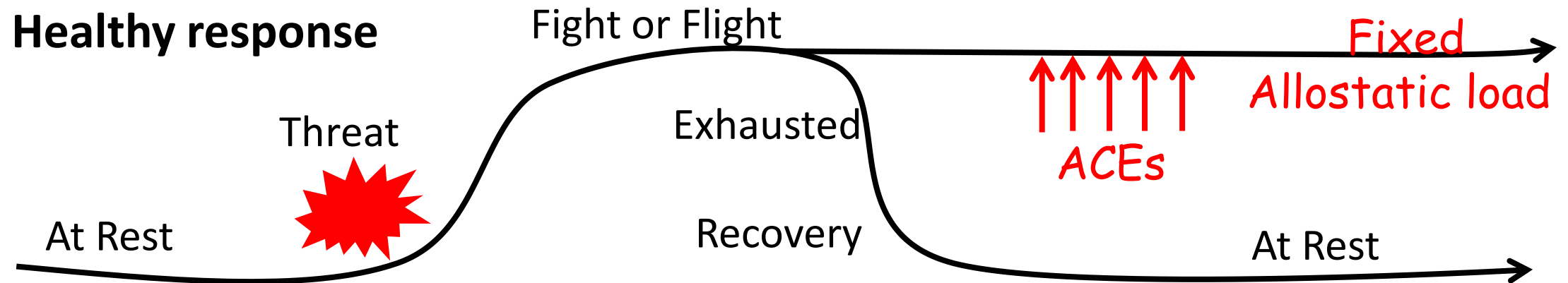
- Adverse Childhood Experiences (ACEs) are very common
- **40%** reported +2 and **12.5%** reported +4
- ACEs are strong predictors of adult health risks and disease
- There is a cumulative effect
- ACEs are implicated in *the 10 leading causes of death in the U.S.*

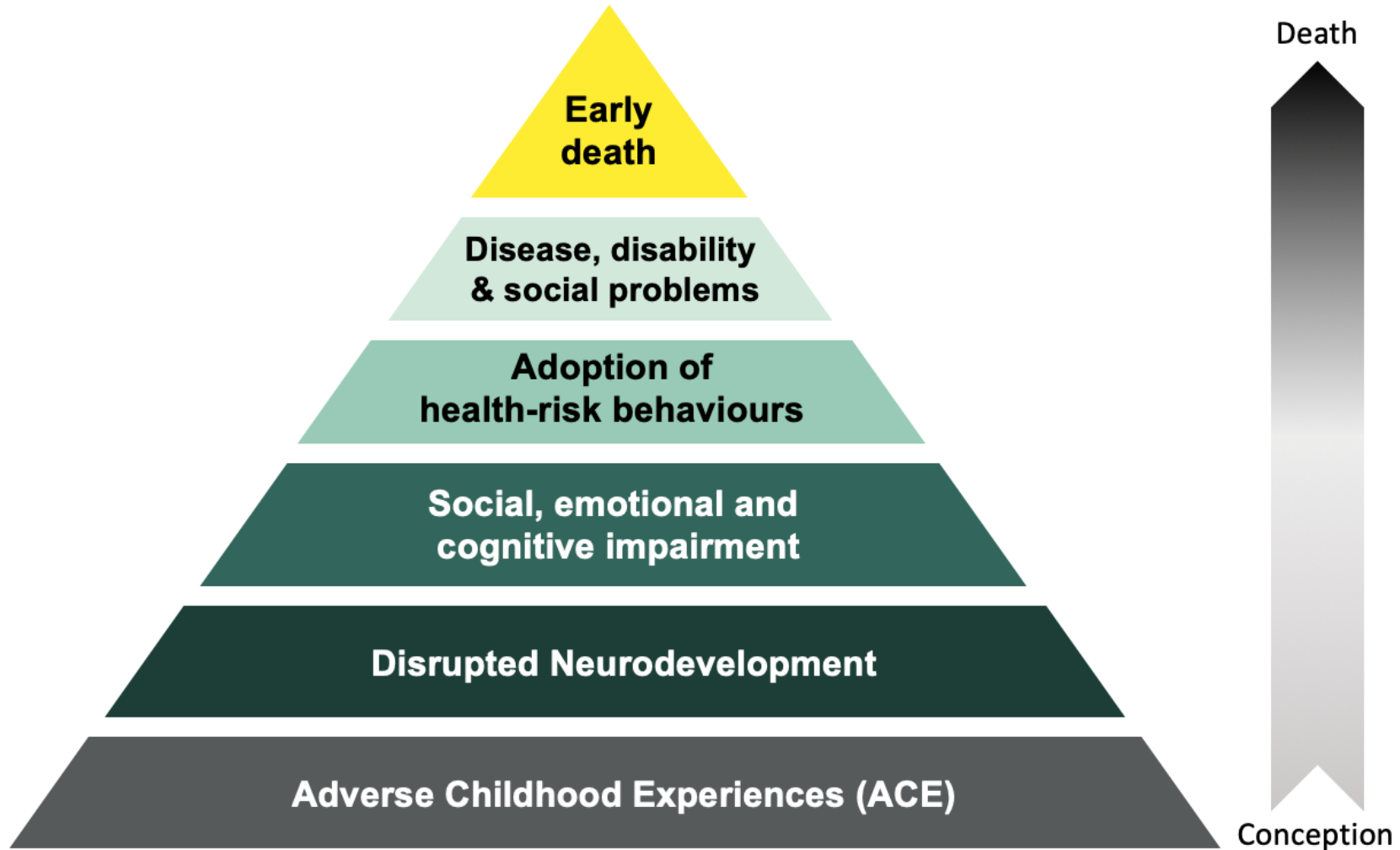


*“I was actually stunned and I wept over what I saw.”*

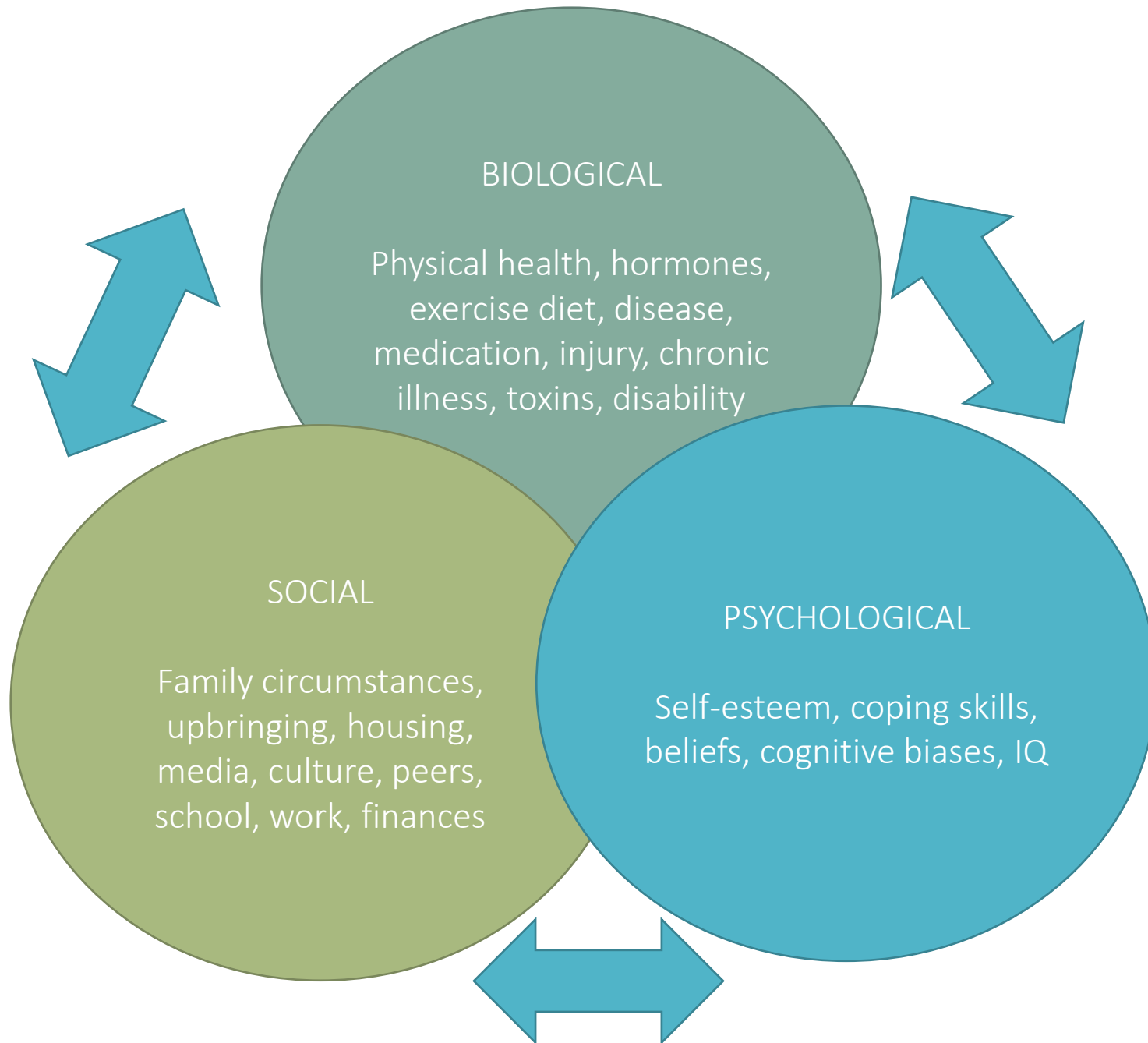
ACEs researcher Rob Anda, M.D.

# The physical impact of early trauma (ACEs)





**Mechanism by which Adverse Childhood Experiences<sup>1</sup> Influence Health and Well-being Throughout the Lifespan**



# Summary so far....

Physical health problems can cause psychological distress

Psychological distress is mediated or moderated through attachment behaviours

The sick role impacts social functioning

Clients with history of trauma more likely to have chronic illness

# Alexithymia

No words for feelings

Inability to express emotions in words

Difficulty perceiving and expressing emotions & body sensations

Associated with poorer immune functioning

High rates in chronic illness

Linked to depression

Asthma: underestimating severity of attack

Diabetes: weak glycaemic control

Heart attack: delayed response in seeking help



# Polyvagal theory – Dr Stephen Porges

<https://youtu.be/ec3AUMDjtKQ>

Explains how your autonomic system interacts with the world

Neuroception – how your nervous system takes in info and assesses safety

Inside your body – pain, discomfort

Outside your body – community/society, comfort

Between neuro systems – picking up cues from others, welcome, safety

Importance of safety in relationships

# Polyvagal Ladder

## Dorsal

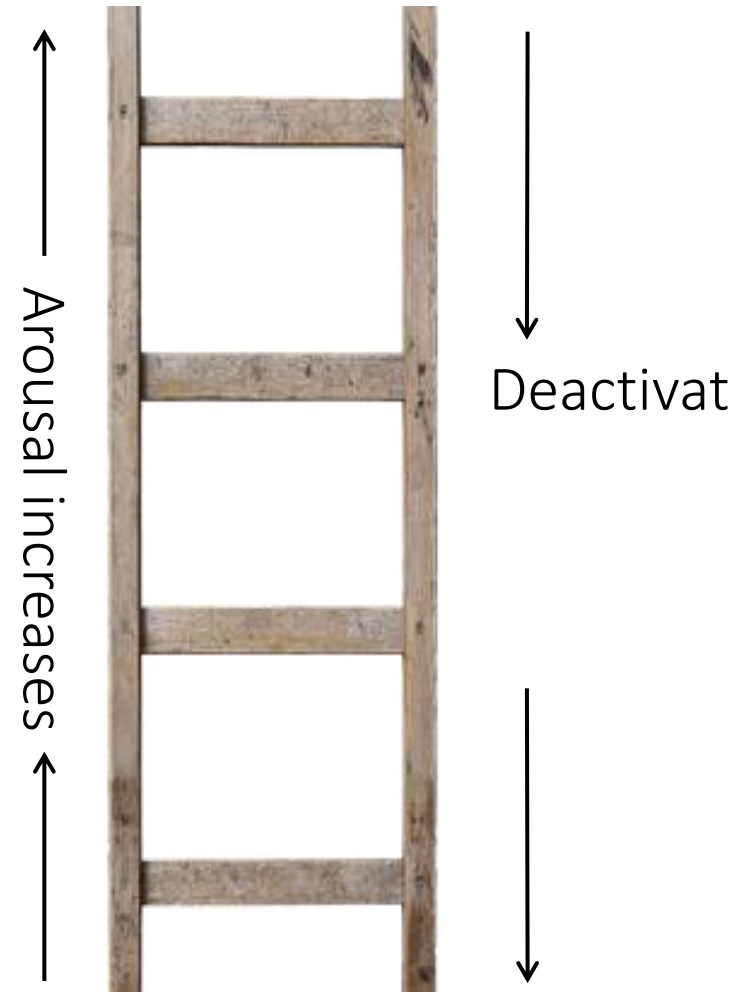
'shut down', disconnected, collapse, no energy, numb, 'you don't exist'

## Sympathetic

'fight or flight', mobilization, no longer care about social connection

## Ventral

'rest and digest', allows us to connect, 'I'm organised enough to deal with this'



# Summary so far....

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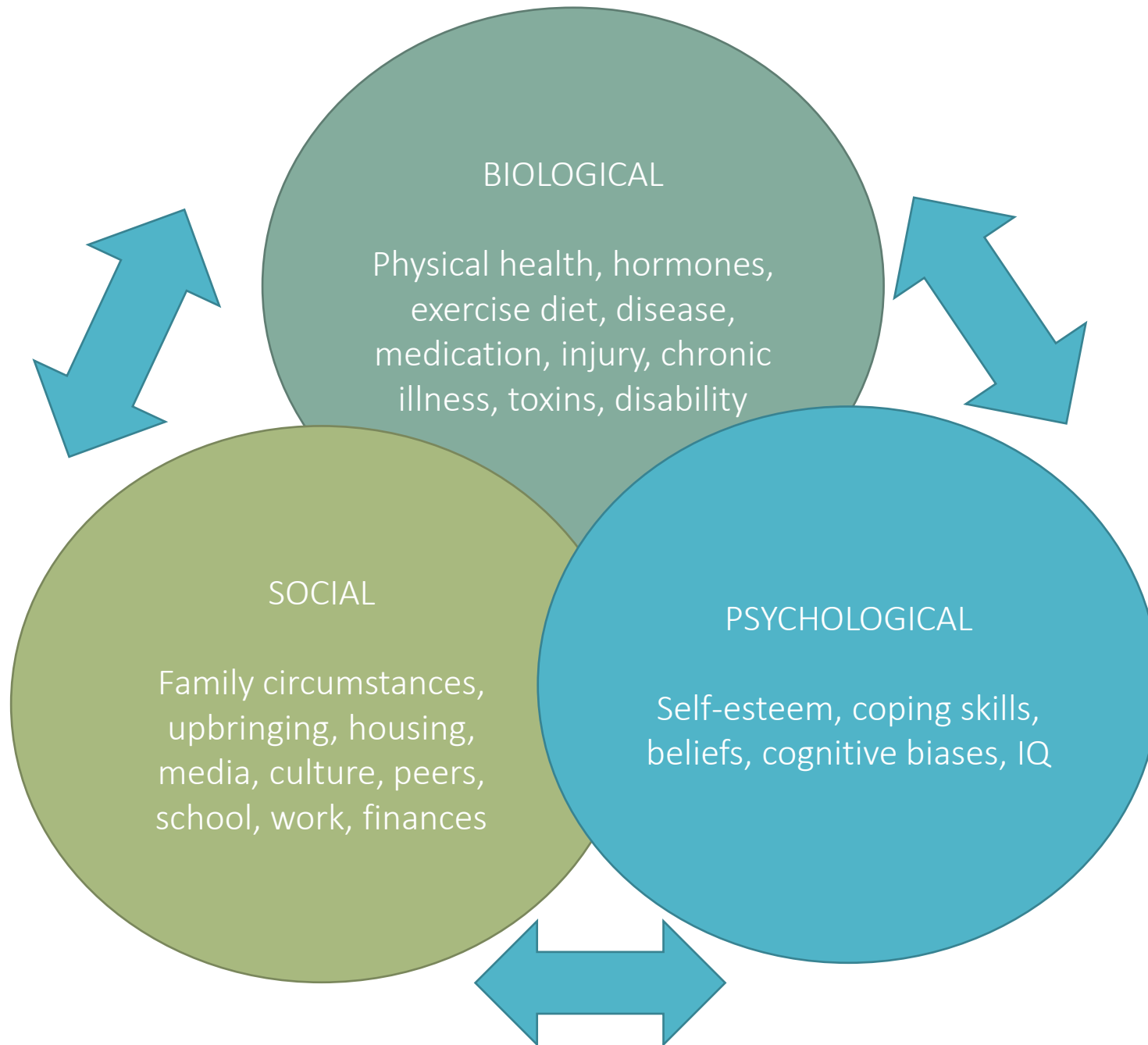
Psychological distress is mediated or moderated through attachment behaviours

The sick role impacts social functioning

Clients with history of trauma more likely to have chronic illness

Chronic illness can impact awareness of and expression of emotions

The autonomic system regulates how we react to threat signals



# Thinking about the gut

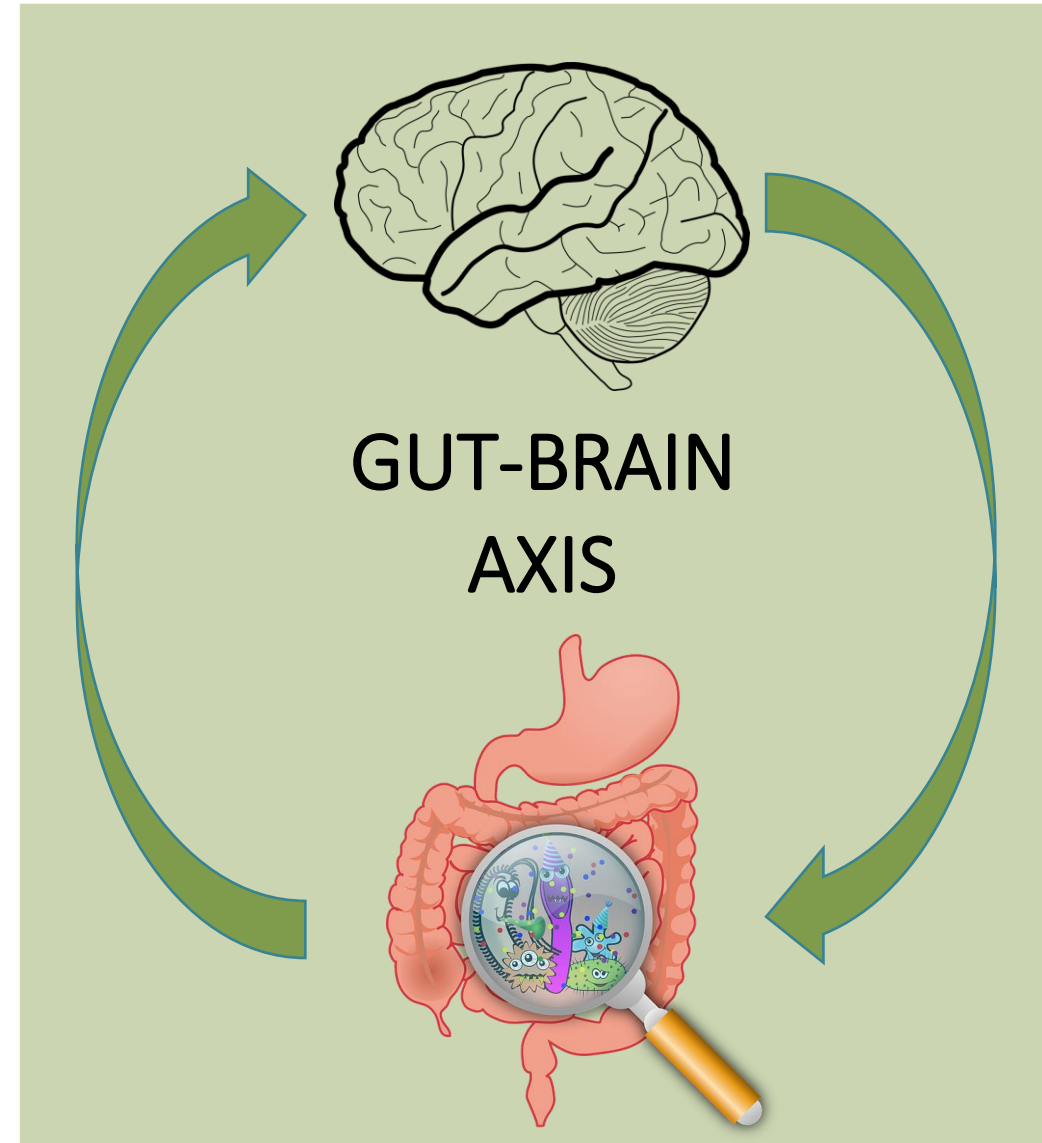
Gut microbiome is as diverse as the Amazon rainforest

10x the number of microbial cells in the human gut than in the whole human body,

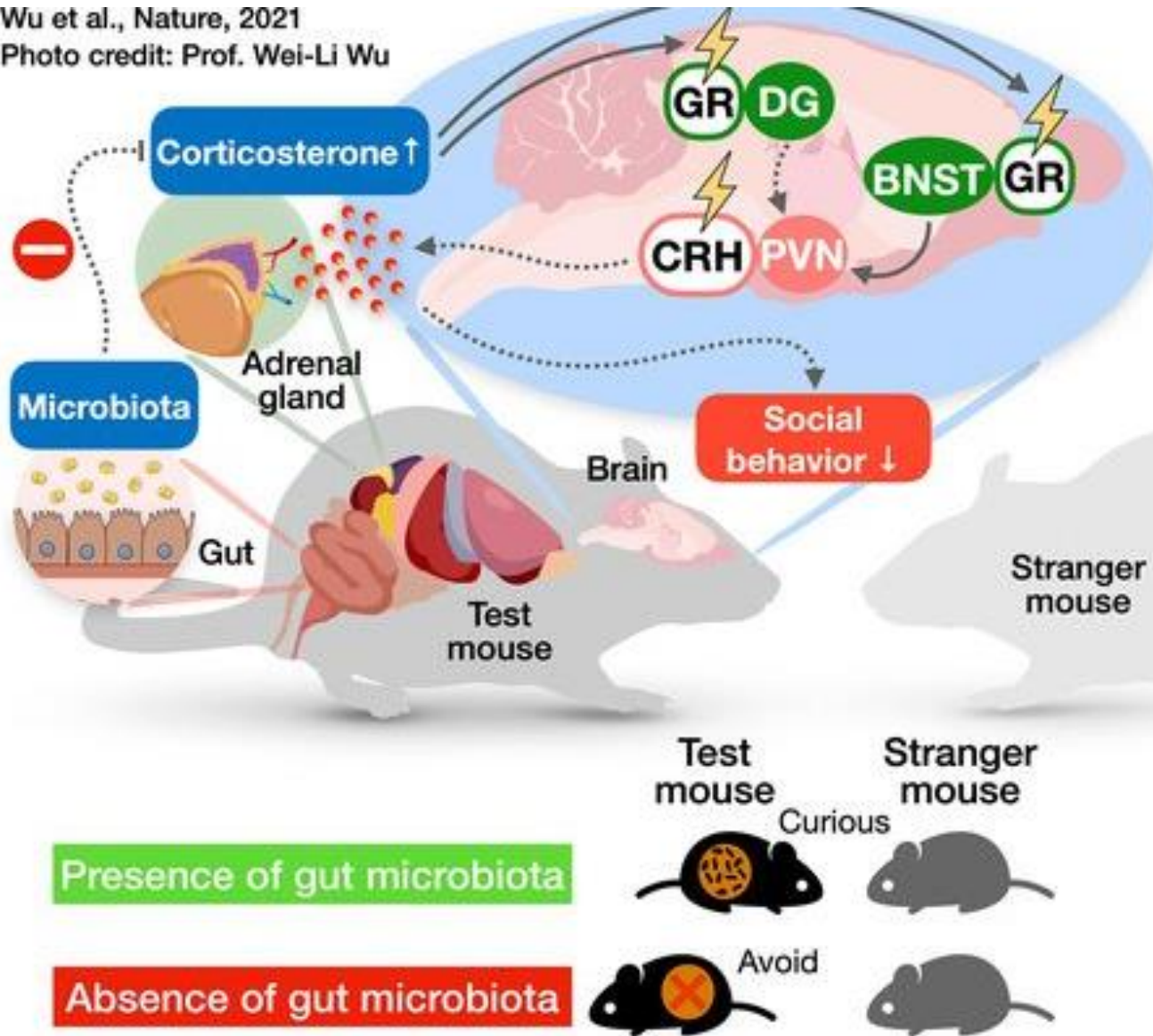
100 trillion microbes representing as many as 5,000 different species and weighing approximately 2 kilograms

Acts as a factory producing chemicals our bodies need to function

90% serotonin produced in the intestine



Wu et al., Nature, 2021  
Photo credit: Prof. Wei-Li Wu



In mice:

Increase in stress response

Decrease in sociability

Fecal transplant changes activity of neurons and behaviour

Transplantation of microbes from depressed patients into rodents results in depression-related behaviours

Probiotic supplementation or food products influences depression-related behaviour in animals

# Evidence in humans

Clinically, differences in patterns of faecal microbiota, reflecting decreased gut microbiota richness and diversity, have been reported in depressed patients compared with healthy controls

Research from university of Cork: a diet enriched with fibre and fermented foods has beneficial effects on stress responses in healthy volunteers after just one month

A meta-analysis of thirteen observational studies reported that consumption of a healthy diet was associated with reduced odds of depression

Psychobiotics – limited evidence but a systematic review of 12 studies, 6 found that probiotics to reduce depression, while two found probiotics to reduce anxiety

Marx, W. et al. Diet and depression: Exploring the biological mechanisms of action. *Mol. Psychiatry* 2021, 26, 134–150.

Lai, JS, et al. (2014) . *Am J Clin Nutr* 99, 181–197.

Smith KS, Greene MW, Babu JR, Frugé AD.. *Nutr Neurosci.* 2021 Dec;24(12):963-977. doi: 10.1080/1028415X.2019.1701220. Epub 2019 Dec 20.

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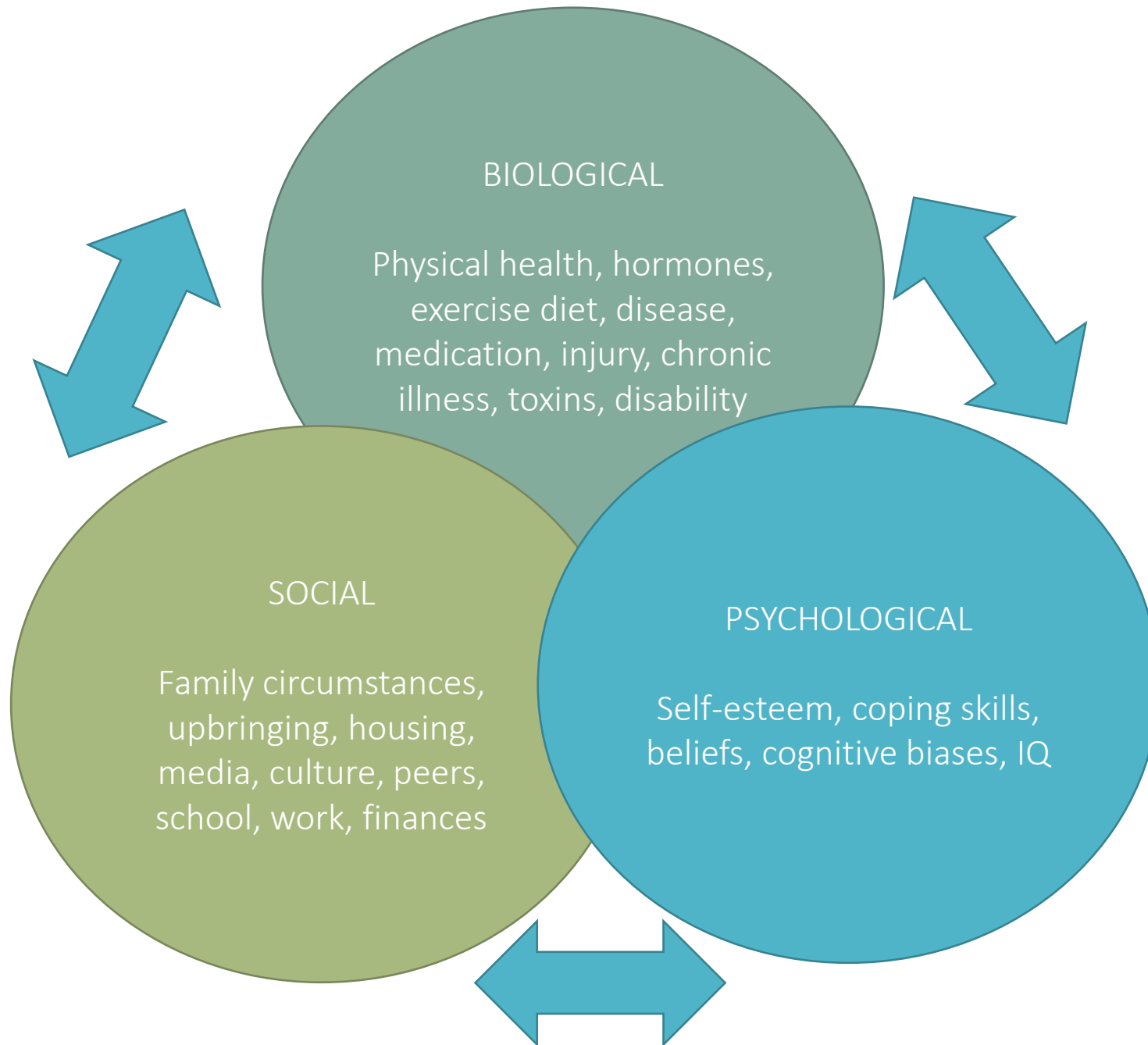
Clients with history of trauma more likely to have chronic illness

Chronic illness can impact awareness of and expression of emotions

The autonomic system regulates how we react to threat signals

The gut microbiome can influence stress, sociability and mood





How do physical health problems show up in your clients?

How do physical health problems impact the therapeutic relationship?

How do physical health problems impact IPT?

Time for reflection

Feedback

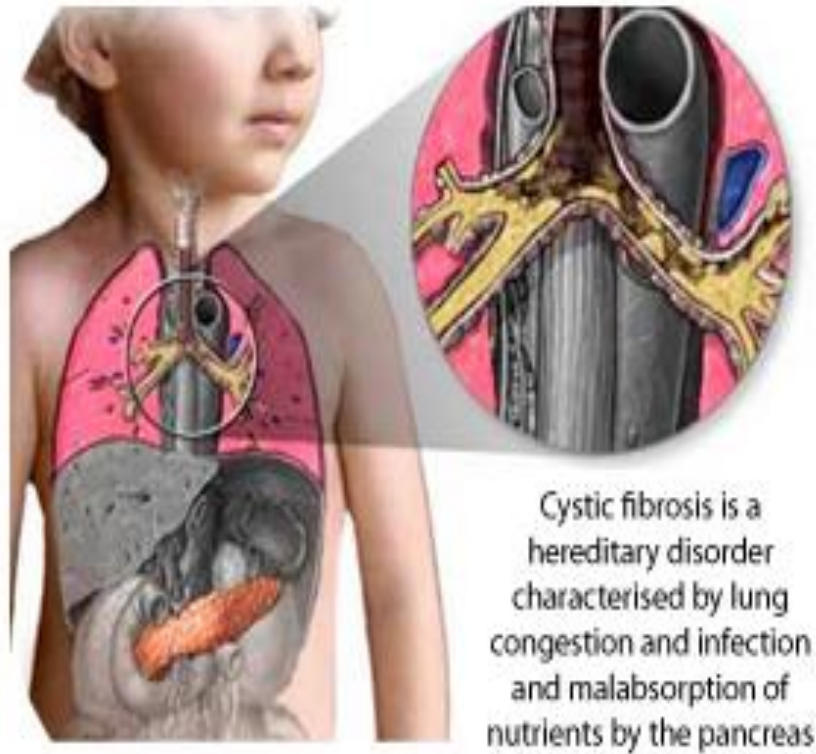


Lunch

# Case studies

# Case study 2

# The impact of CF on interpersonal functioning

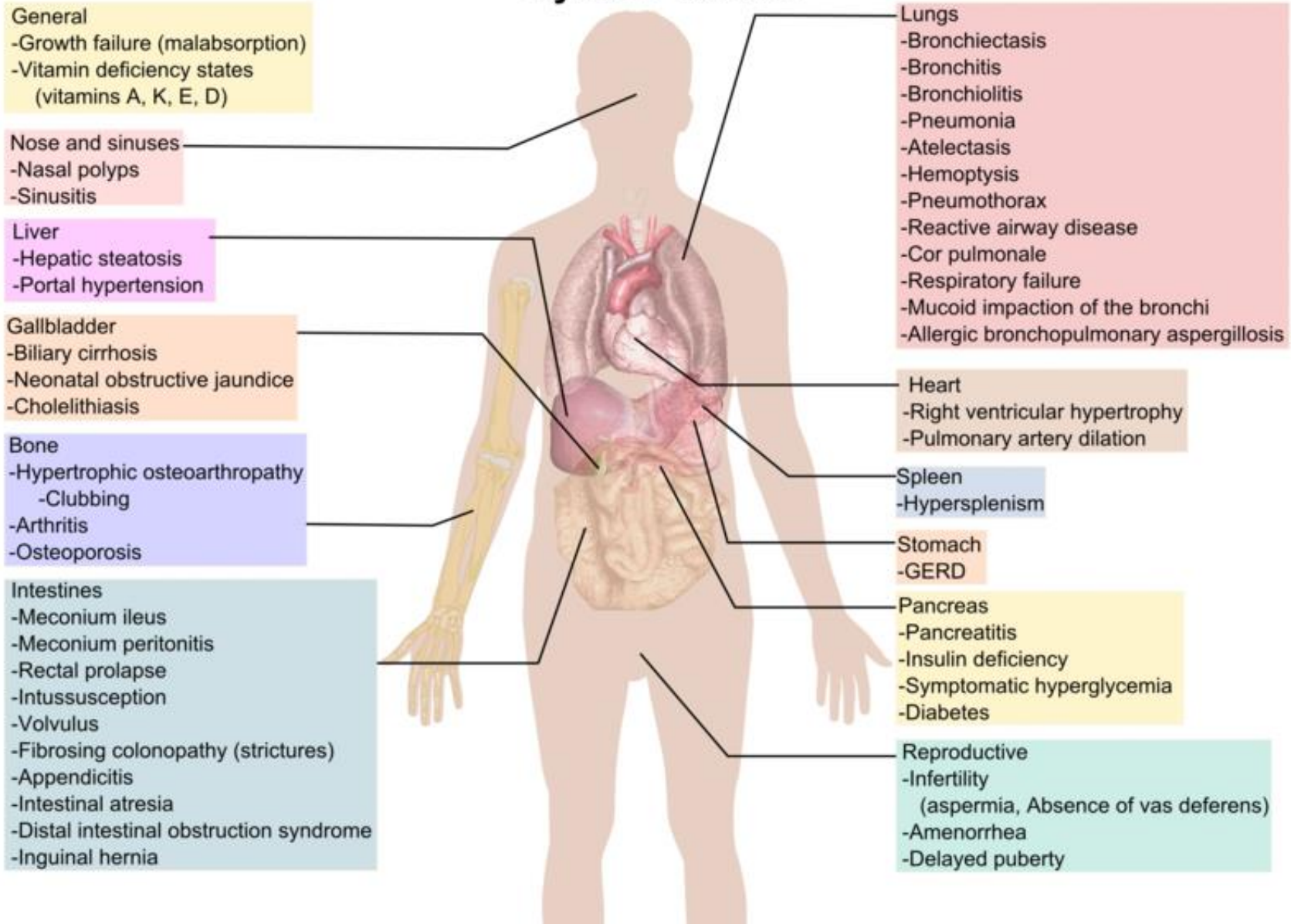


CF is caused by a single faulty gene that controls the movement of salt in the body.


The internal organs become clogged with thick, sticky mucus resulting in infections and inflammation.

This makes it hard to breathe & digest food.

# Manifestations of Cystic Fibrosis





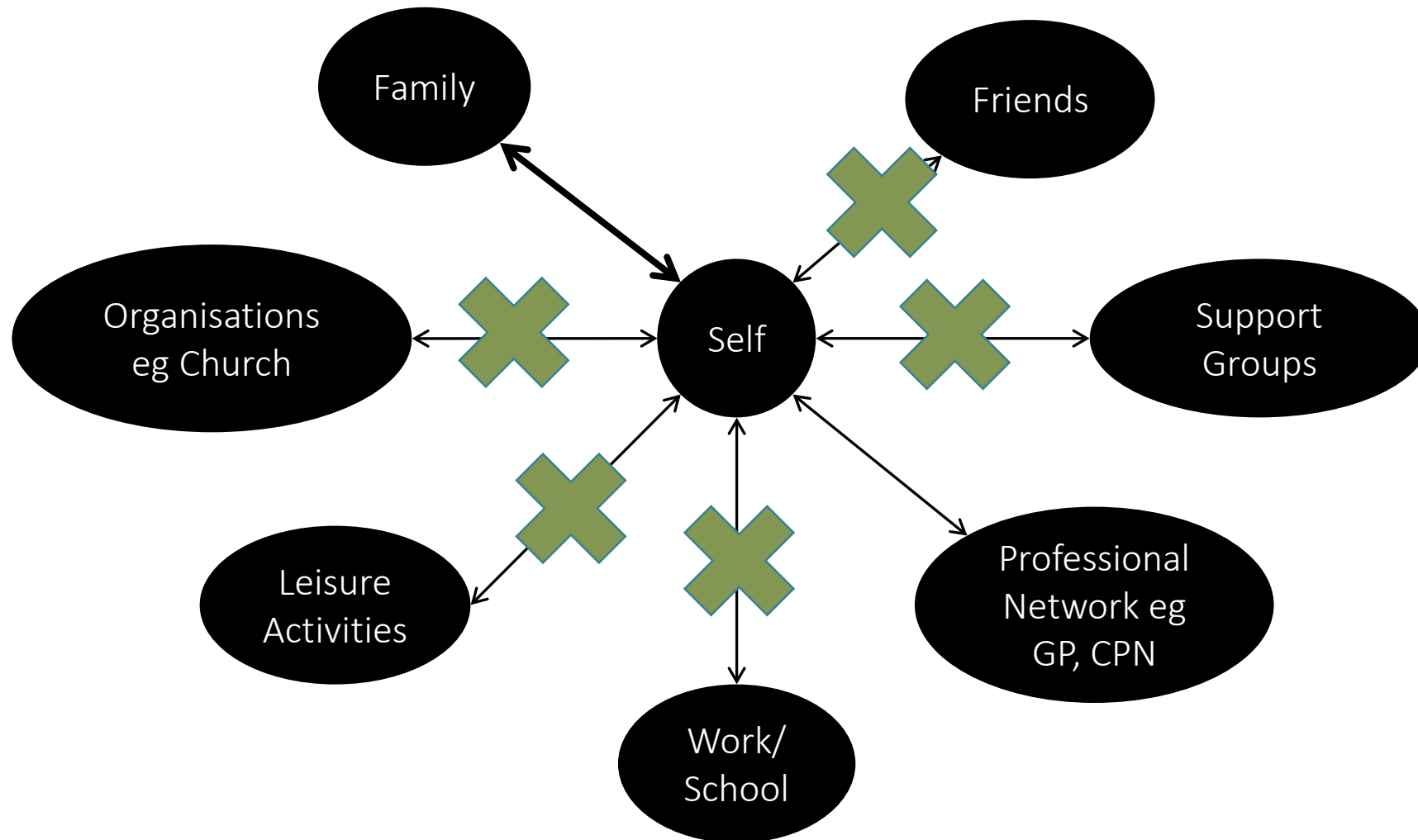
A photograph of a paved road with a white double line down the center, blocked by a large, dark brown tree trunk that has fallen across it. The road is surrounded by dense green trees and foliage. Three text boxes are overlaid on the image: a white box at the top, a red box in the middle, and a teal box at the bottom.

Increased dependence  
on family

Worsening health

Moving into adulthood

# Impact of CF on Relationships



# Themes in CF/chronic illness

Attachment issues 'Don't love him too much'

Opportunities for relationships

Relationships in teen years – discrimination, bullying, 'secrets'

Expression of distress

Distress in social network

Limited social network

Living with uncertainty

Life goals and ambitions

# Bringing 'health' into the formulation

Weekly symptom review

Interpersonal inventory

Timeline -building in another line above the depression

Thinking about the interactions in the formulation

Considering consultation where appropriate

# Summary before practice

What do we need to thinking about?

What questions do we need to ask?

How do we/ do we adapt IPT?



# Assessment tweaks and tuning in

Screening tools for diagnosing depression

Medications as confounding factors (psychotropics, neuroleptics, opioids)

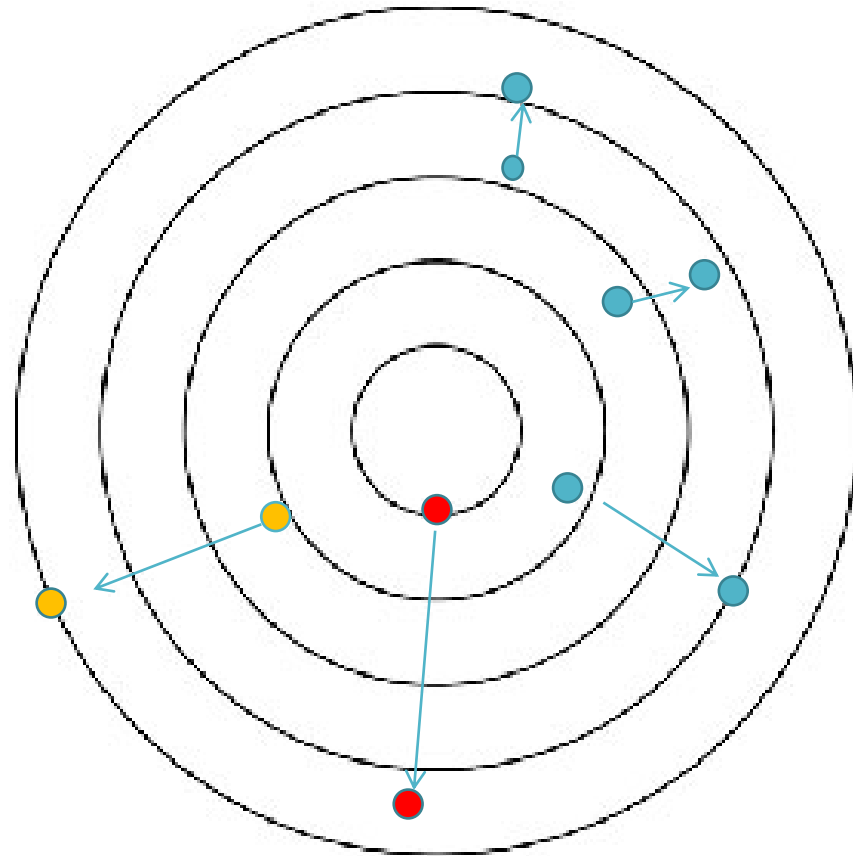
Plotting health timeline alongside depression timeline

Moderating use of interpersonal inventory and closeness circle

Consider consultation where appropriate and with consent

Bring health into the formulation interactively

# Interpersonal inventory



# Formulation template example

Infectious agents  
Environmental toxins  
Genetic predisposition  
Physiological reactivity  
Immune response  
Diet

Cultural  
Spiritual

Social support  
Health education and  
beliefs  
Pollution control  
Sanitation  
Access to medical care  
SES and opportunities

Stress  
Coping strategies  
Personality  
Health related habits  
Reactions to illness  
Attachment and IWM  
Trauma history



# Putting it into Practice

2-3 case scenarios

How might this affect assessment and the tools you use?

How do you ask about physical health?

How might you plan therapy?

Feedback

# Takeaway messages

Don't underestimate the  
biopsychosocial model

It's okay not to know – ask

What changes will you make?

Identify other training needs